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ABSTRACT

This text has been prepared in an effort to explain what the Uniform Act contains, intends to do, and cannot do. It also examines mehtods by which the Act can be implemented as well as the manner in which implementation can be accomplished most effectively. Working within the parameters of the overall alcohol problem, it also addresses the major questions and concerns confronting the police, courts, and medical/rehabilitation personnel. (Author)

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THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

LAW ENFORCEMENT GUIDELINES

INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE, INC.

POLICE MANAGEMENT AND OPERATIONS DIVISIONS

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Alcohol, Drug Abuse, and Mental Health Administration
National Institute on Alcohol Abuse and Alcoholism

CG 011962

THE
UNIFORM ALCOHOLISM AND INTOXICATION
TREATMENT ACT

LAW ENFORCEMENT GUIDELINES

by the

Police Management and Operations Divisions
INTERNATIONAL ASSOCIATION OF CHIEFS OF POLICE
Eleven Firstfield Road, Gaithersburg, Maryland 20760

August 1976

Law Enforcement Code of Ethics

As a Law Enforcement Officer, *my fundamental duty is to serve mankind; to safeguard lives and property; to protect the innocent against deception, the weak against oppression or intimidation, and the peaceful against violence or disorder; and to respect the Constitutional rights of all men to liberty, equality and justice.*

I will *keep my private life unsullied as an example to all; maintain courageous calm in the face of danger, scorn, or ridicule; develop self-restraint; and be constantly mindful of the welfare of others. Honest in thought and deed in both my personal and official life, I will be exemplary in obeying the laws of the land and the regulations of my department. Whatever I see or hear of a confidential nature or that is confided to me in my official capacity will be kept ever secret unless revelation is necessary in the performance of my duty.*

I will *never act officiously or permit personal feelings, prejudices, animosities or friendships to influence my decisions. With no compromise for crime and with relentless prosecution of criminals, I will enforce the law courteously and appropriately without fear or favor, malice or ill will, never employing unnecessary force or violence and never accepting gratuities.*

I recognize *the badge of my office as a symbol of public faith, and I accept it as a public trust to be held so long as I am true to the ethics of the police service. I will constantly strive to achieve these objectives and ideals, dedicating myself before God to my chosen profession . . . law enforcement.*

FOREWORD

The objective analysis of statistics gathered from many sources has resulted in an incontestable consensus that alcoholism and alcohol abuse are problems of major proportions in the United States. Although many of our citizens suffer from health and social problems stemming from the abuse of alcohol, the public drunkard is probably the most noticeably tangible evidence of the presence of alcoholic persons and the existence of alcoholism in our society.

The traditional method of combatting the embarrassing problem of the public inebriate has been to pass the individual concerned through the criminal justice court system. Without question, no other general class of "offense" or "offender" has been subjected to this type of judicial process, which has as its star actor the "revolving door" alcoholic person. This description aptly fits the public inebriate whom fate has condemned to indeterminate confinement on the treadmill of intoxication, arrest, conviction, sentence, imprisonment, release, intoxication... This seemingly never-ending cycle has also been a truly disappointing experience for police administrators and judges. The police officer, the magistrate, and the "offender" know that they are riding on a merry-go-round of frustration.

It is heartening to note, however, that in the recent past certain legislative actions and court decisions have made it comparatively apparent that public drunkenness, by itself, should not be considered as a criminal offense. Relatively early proceedings in this regard, which hitherto would have been considered to be legislative or judicial exceptions or errors, were merely extensions or buttresses of certain recommendations promulgated in 1967 by the Task Force on Drunkenness of the President's Commission on Law Enforcement and Administration of Justice. Particularly, the Task Force on Drunkenness recommended that:

> Drunkenness should not in itself be a criminal offense. Disorderly and other criminal conduct accompanied by drunkenness should remain punishable as separate crimes. The implementation of this recommendation requires the development of adequate civil detoxification procedures.[1]

that:

---

[1]The President's Commission on Law Enforcement and Administration of Justice, Task Force Report: Drunkenness (Washington, D.C.: U.S. Government Printing Office, 1967), p. 4.

> Communities should establish detoxification units as part of comprehensive treatment programs.[2]

and, that:

> Communities should coordinate and extend aftercare resources, including supportive residential housing.[3]

Later, "To provide a comprehensive Federal program for the prevention and treatment of alcohol abuse and alcoholism," the unanimous passage of Public Law 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970[4] gave further impetus to the marshalling of strength to overcome the forces of alcoholism/alcohol abuse attacking the country. In this regard, aside from establishing the National Institute on Alcohol Abuse and Alcoholism, the Comprehensive Act was also cited by the then Secretary of Health, Education and Welfare, Elliot L. Richardson, as "...bringing together diverse and often divided interests in our society in support of a major public health measure."[5]

Again, in August 1971, another major forward step was taken along the path toward the development of a "...consistent pattern of alcoholism legislation throughout this country ..."[6] This progressive approach was exemplified by a document entitled the "Uniform Alcoholism and Intoxication Treatment Act" drawn up and approved by the National Conference of Commissioners on Uniform State Laws at its annual meeting in Vail, Colorado. The conference recommended that the Act be adopted by all of the states.

The Act declares that alcoholic and intoxicated persons should receive "treatment" instead of being subjected to criminal prosecution because of their consumption of alcoholic beverages. In other words, the provisions of the Act look upon alcoholism as a disease and as a public health problem. Although the Uniform Act excises alcoholism, per se, from the criminal justice system, it does not change any of the legal safeguards which act as protectors of the public's safety. For reference purposes, a copy of the model law has been appended to this manual.[7]

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[2] Ibid., p. 5.

[3] Ibid.

[4] See Appendix C.

[5] U.S. Department of Health, Education, and Welfare, National Institute on Alcohol Abuse and Alcoholism, Alcohol and Health (Washington, D.C.: U.S. Government Printing Office, December 1971), p. 4

[6] Ibid.

[7] See Appendix B.

In 1973, strong support was given by the National Advisory Commission on Criminal Justice Standards and Goals to the actions of the National Conference of Commissioners on Uniform State Laws at its Colorado meeting. In its report, A National Strategy to Reduce Crime, the commission recommended with respect to the decriminalization of drunkenness that:

> ...drunkenness in and of itself should not continue to be treated as a crime. All States should give serious consideration to enacting the Uniform Alcoholism and Intoxication Act.[8]

Currently, almost half of the states, the District of Columbia, and the Commonwealth of Puerto Rico have adopted the Uniform Act in one form or another. Other states have enacted similar legislation, but have not decriminalized public acts manifested by intoxication such as staggering, lying down, sleeping on a park bench, lying unconscious in a gutter, begging, singing, etc. The remaining state legislatures have either considered the model legislation, or similar bills, and have rejected it; have introduced the Uniform Act, but not acted upon it; or have not considered the Uniform Act or any similar legislation. The probable reasons for legislative inaction or outright rejection are many. A few of the grounds upon which declination or lack of action may be based are:

- A misunderstanding concerning the intent of the Uniform Act
- A lack of understanding of the nature of alcoholism—a belief that alcoholism is self-induced and not even a disease
- A belief that intoxication, of itself, will be accepted as a defense for the commission of criminal acts
- A belief that legislation of the type exemplified by the Uniform Act cannot work
- A difficulty in understanding how to execute the provisions of the Uniform Act in a practical manner
- A belief that "the old ways are the best ways"—opposition to change

[8]National Advisory Commission on Criminal Justice Standards and Goals, A National Strategy to Reduce Crime (Washington, D.C.: U.S. Government Printing Office, 1973), p. 205.

- A lack of planning for or a means of implementing alternative actions by responsible agencies

- A lack of sufficient funds to develop alternatives

- Any combination of the above

Although many forward-looking police administrators are of the opinion that legislation typified by the Uniform Act is long overdue, other highly respected law enforcement authorities have serious reservations regarding:

- The feasibility of such legislation

- The ultimate consequences of such legislation, if enacted

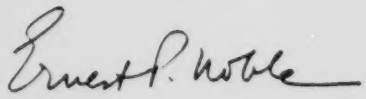
Because of the existence of certain varied and often misleading interpretations of the Uniform Act, and, primarily, due to the advancement of individually held parochial viewpoints by some law enforcement officials and members of other professions affected by the Act's provisions, this text has been prepared in an effort to explain what the Uniform Act:

- Contains
- Intends to do
- Cannot do

This manual also examines methods by which the Act can be implemented as well as the manner in which implementation can be accomplished most effectively. Working within the parameters of the overall alcohol problem, the following pages also address the major questions and concerns confronting the police, courts, and medical/rehabilitation personnel.

The manual, supplemented by a separately published instructor's guide, has been designed especially for use in the training of police officers and for others who may be interested in law enforcement applications with respect to the Uniform Act. Serious and thoughtful consideration of the material comprising this text, coupled with judicious application of the knowledge acquired will greatly support the advance of professionalism within the law enforcement community. Other individuals who read this manual should benefit by gaining a better understanding of the Act's implications for the criminal justice system.

More importantly, perhaps, the acquisition of this knowledge may speed the day when appropriate treatment is uniformly accorded to alcoholics and intoxicated persons.



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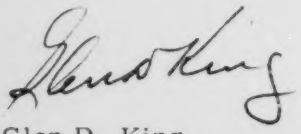

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Further, the IACP is pleased to recognize the following professional staff members who gave direction to the overall project, collected data, prepared copy, or otherwise contributed to the manual's content and preparation of the associated instructor's guide:

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An endeavor of this nature requires extensive fieldwork for the collection and compilation of data for subsequent analyzation and presentation. Consequently, it was necessary to solicit the cooperation of and to coordinate with representatives of numerous law enforcement offices and other agencies concerned with alcohol abuse and alcoholism.

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- San Diego County Men's Alcohol Detoxification Center, San Diego
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ADMINISTRATIVE NOTE

In this text, unless direct reference is being made to a particular individual, the use of the masculine gender also includes the feminine gender.

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CHAPTER
I

I

THE NATURE OF ALCOHOL AND ALCOHOLISM

Overview

It may seem unnecessary to note in this manual at the very outset that even the most detailed understanding of the nature of alcohol as a chemical substance by itself cannot possibly resolve the problems associated with its use and abuse. It should be obvious that other even more complicated factors are also involved, namely the nature of the person, the drinker; the sum total of his or her experiences from infancy on; and the nature of the society in which the person lives. Nor is drinking alcohol by itself the cause of alcoholism any more than eating carbohydrates is the cause of diabetes. In both conditions, consuming a chemical compound is necessary to give rise to symptoms of an illness, but it is not, alone, sufficient. Simultaneously, other requisites must also be present. In the case of alcoholism, what are they?

Alcohol is imbibed in beverages by well over 90 million Americans.[1] A Gallup Poll of adults in 1974 indicated that close to 70 percent of the population drink.[2] Some drink "lightly," some "moderately," and some more "heavily." Surveys of high school students have shown that 71 percent to 92 percent have at least tried alcoholic beverages. The frequency of drinking and the quantity consumed are seen to increase with age and school grade.[3]

Most of these individuals, however, do not seem to suffer any significant ill effects. They may be drinking alcohol for different reasons at different times; because they like or need its effect on their mood and feelings, because it enhances a meal or a ceremonial occasion, because it is a social drink, etc. Those who abstain may do so for opposite reasons, perhaps because of a religious proscription or because of some experience with or fear of the harmful effects of alcohol intoxication.[4]

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[1]D. Cahalan, I. H. Cisin, and H. M. Crossley, American Drinking Practices: A National Survey of Drinking Behavior and Attitudes (New Brunswick, N. J.: Rutgers Center of Alcohol Studies, 1969).

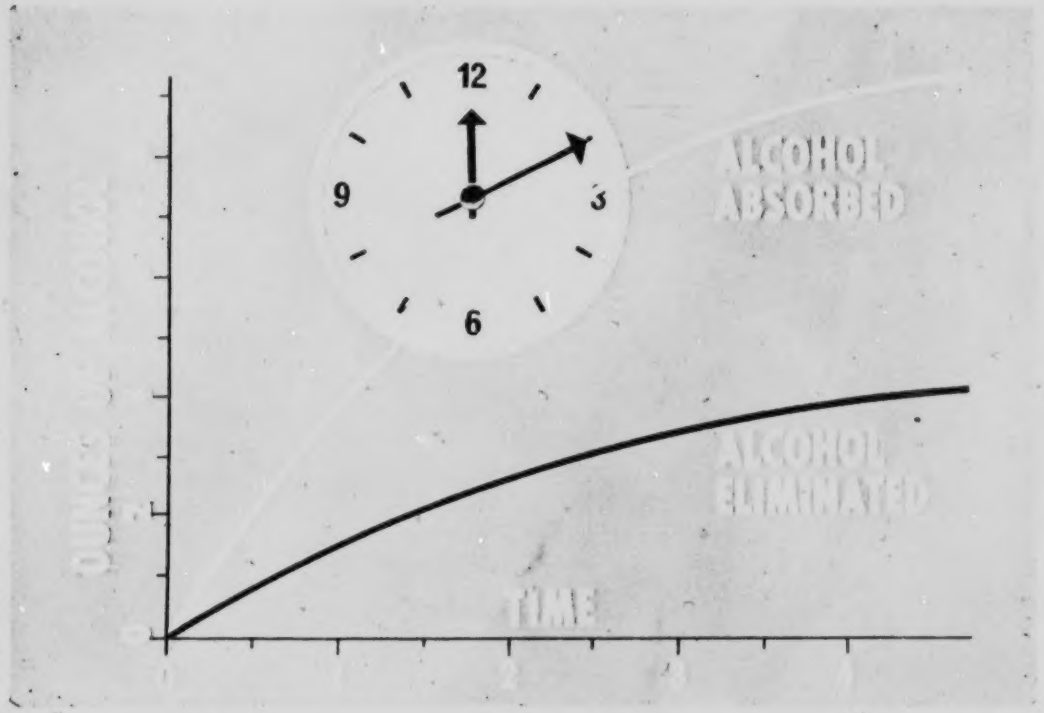
[2]G. Gallup, "The Rising Number of Drinkers," The Washington Post, June 10, 1974, p. B2

[3]M. Bacon and M. D. Jones, Teenage Drinking (New York: Crowell, 1968).

[4]Many "abstainers" may, of course, be consuming alcohol, wittingly or unwittingly, as a prescribed medicine or in medicinal elixirs where alcohol serves as a solvent or vehicle for other drugs. The alcohol content may then be as high as in whiskey or strong wines and have the same consequences as if it were consumed as a beverage. Then, too, some individuals refrain from drinking alcoholic beverages because one or more of the ingredients may induce in them an allergic condition.

While millions of Americans have found that alcohol may be a palatable, relatively harmless, and even useful ingredient of a social drink when controlled in its consumption, it is nevertheless a drug just as caffeine is a drug in coffee, tea, and colas. However, alcohol is vastly more toxic, with an infinitely greater risk of harm.

Within a few minutes of being swallowed, alcohol is absorbed from the stomach and small intestine and circulated in the blood over and over again to every cell in the body until it is oxidized, mainly by the liver, and ultimately removed. Alcohol quickly reaches the brain where it essentially depresses or "anesthetizes" the activity of nerve



cells in the manner of other and more sedative drugs. It first acts on the "higher" brain centers which control judgment and feelings, then motor coordination, locomotion, reflexes, and eye movements. With rising concentration in the blood, the "lower" respiratory and circulatory centers may be so depressed that death ensues.

With the repeated use of even a small amount, tissues become more "tolerant" to alcohol so that the effect, whatever it may be, of that small amount is no longer attained. To achieve the same effect, the individual may find himself or herself gradually consuming larger and larger amounts of alcohol. The individual may then ultimately be regarded as a "heavy" drinker, able to "hold" liquor far better than less experienced drinkers.

Such drinking may well be considered to be within the normal range regardless of the quantity consumed—if the individual's life or functioning is not disturbed because of it. In such cases, at any sign of difficulty, the drinking is usually controlled or limited. If it isn't, however, the individual progresses through what might be called the "problem drinking" stage to a loss of control or obvious dependence on the drug, alcohol. This condition is defined as alcoholism.

Dependence on or addiction to alcohol usually comes about gradually over a period of many years, but in some people it may be experienced almost immediately—sometimes with the first drinking experiences. The individual, whether man, woman, or child,[5] is typically unaware of any pathological change and, in fact, may resent having his or her attention called to these changes by family members, friends, colleagues, or even a physician. Denial, indeed, is characteristic of developing alcoholism. Nevertheless, the individual becomes intoxicated more frequently and may stay drunk longer, even for several days.

The person soon drinks symptomatically, to get rid of a hangover, to alleviate depression, or to avoid the problems of living which, paradoxically, are often caused by his drinking. These problems may relate first and foremost to his family, but may also cover the gamut of job deterioration, financial losses, accidents in driving, antisocial behavior such as combativeness and belligerence, involvement with police and the law, and, of course, his health.

Early in the progression of symptoms, the alcoholic person may experience "blackouts" or amnesia for hours or days of his drinking life. He skips meals when drinking and may even show signs of severe malnutrition. Periodically, he may make an effort to reduce his intake or even abstain completely, but usually he will resume drinking unless he gets help. He may find himself with symptoms of withdrawal due to a now physiological dependence on alcohol—without which he cannot function as he did formerly. He may awaken with an overwhelming sense of anxiety, with the "shakes," sweating, and frightening hallucinations. He may even suffer delirium tremens, with convulsions, a sometimes fatal condition when left untreated. The alcoholic person soon learns that self-medication with alcohol can relieve the symptoms, but he is now caught in this addictive cycle.

Of the almost 100 million Americans who are not abstainers, who do drink, approximately ten million succumb to this illness of alcoholism—one out of ten! They are found at all social and economic levels, in all racial and religious groups, and in all occupations and professions. The number who progress to the extreme form of the illness, such as is often found in the skid-row population, represent less than five percent of the total. It is this group which most often comes in contact with the police through the so-called "crime" of public intoxication.[6]

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[5] D. Sherwin and B. Meade, "Delirium Tremens in a Nine-Year-Old Child," American Journal of Psychiatry, 132:11, 1975.

[6] In 1968, Maryland became the first state to remove public intoxication from the criminal justice system, legislating a program of health care and social rehabilitation for those suffering from alcoholism, now defined as an illness. In 1971, the National Conference of Commissioners on Uniform State Laws approved a similar Alcoholism and Intoxication Treatment Act, and recommended its enactment in all states; by 1976, 25 had abolished public intoxication as a criminal offense.

Whereas the homeless, public inebriate represents only the "tip of the iceberg" and is readily identifiable as being alcoholic, the great bulk of the alcoholic population is superficially indistinguishable from the rest of the "normal," nonalcoholic population. However, the members of this alcoholic majority are in varying stages of the illness and may still be employed, with their families intact, but considerably scarred. As with other serious, progressive diseases, the earlier an alcoholic person can be identified and treated, the higher will be the rate of recovery from the illness.

What causes these ten million American men, women, and children to succumb to this illness? The simple answer is, "No one knows." In the present state of our knowledge, the causes of alcoholism are unknown. Speculations and theories are rife, but none of them has yet been established as fact. It has been said that "Many a beautiful hypothesis has been slain by an ugly fact.". A multitude of factors is probably involved in the case of every alcoholic.

Recently, increasing evidence has implicated heredity as a factor in the development of alcoholism.[7] Offspring of alcoholic parents, adopted and reared from infancy by nonalcoholic parents later show higher rates of alcoholism than their matched controls whose biological parents were not alcoholic. Such evidence, of course, pointing to a constitutional substrate lends weight to the hypothesis that biological factors are involved in the origins of alcoholism; however, specific substantiation is lacking. For years, many researchers have been speculating that specific biological factors dealing with abnormal cell chemistry, enzyme reactions, nutritional deficiency, or endocrine dysfunction were somehow involved.[8] Unfortunately, these studies have not yet produced definitive conclusions about such factors, although promising leads often indicate that a breakthrough in this area may be forthcoming.

Other scientists have opted for the theory that alcoholism results from an inability to cope with underlying emotional difficulties. Psychoanalysts trace alcoholism to overwhelming unconscious needs for dependence, nurturing, self-destruction, striving for power, or "oral gratification" rooted in abnormal childhood development.[9] Some psychologists note that alcoholics generally reveal personality traits that include hostility, low frustration tolerance, passivity combined with aggressiveness, feelings of inferiority combined with attitudes of superiority, perfectionism, phobias, and dependency. Therefore, they have attempted to root the causes of alcoholism in an "alcoholic personality."[10] It can be argued, however, that these personality traits when found in alcoholics may well be a result of their alcoholism rather than its cause.

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[7]D. W. Goodwin, et al, "Alcohol Problems in Adoptees Reared Apart from Alcoholic Biological Parents" (Arch Gen Psychiatry, 28:238-243, 1973).

[8]U. S. Department of Health, Education and Welfare, Public Health Service, DHEW Publication No. ADM 75-212 (Washington, D. C.: U.S. Government Printing Office, June, 1974).

[9]W. McCord and J. McCord, Origins of Alcoholism (Stanford, California: Stanford University Press, 1960).

[10]H. T. Blane, "The Personality of the Alcoholic," Frontiers of Alcoholism (New York: Science House, 1970), pp. 16-28.

Moreover, it can be stated objectively that no common personality structure has yet been found which permits one to predict the onset of alcoholism. This is not to deny that in some emotionally disturbed individuals, such as paranoid schizophrenics, the depressed, and others, excessive drinking may be a maladaptive coping mechanism. If, in these cases, alcoholism develops, it may be regarded as secondary to the primary mental illness.

Other psychologists view alcoholism as a "learned" response to anxieties or fears. They argue that people tend to seek pleasant sensations and attempt to reduce or avoid unpleasant or painful ones. Drinking alcohol is looked upon as a way of reducing or eliminating tension and achieving instead a sense of euphoria, of being "high." Alcoholism is then a result of a reflex response to drink which is continually reinforced by the immediacy of the positive reward. Even the pain and guilt that the alcoholic person may later feel become stimuli for continual, excessive drinking. Although this theory is not widely accepted, it obviously can have important consequences in developing treatment approaches such as aversion conditioning or "teaching" alcoholic individuals how to regain control.

Unfortunately, there is no consistent evidence that alcoholism is a reversible process and that alcoholic persons can return safely to drinking. In fact, the most recent research[11] at the University of North Carolina, involving by far the longest follow-up time (ranging from 27 to 55 months), reported that none of the patients who desperately wanted to bring his drinking under control succeeded in maintaining control throughout the follow-up period. Sooner or later, each one drank with the loss of control typical of alcoholism and quite unlike the controlled social drinking of normal drinkers.[12]

Apart from the physiological and psychological theories just mentioned, one must also be impressed by the striking difference in rates of alcoholism among religious, cultural, ethnic, and national groups. Why should the French, Americans, Scandinavians, Russians, and Poles, for example, show a very high rate of alcoholism whereas the Chinese, Italians, Greeks, Spaniards, and Portuguese exhibit a low rate? Among religious groups why should American Protestants, for example, have a far higher rate of alcoholism than American Jews?

Research sociologists have attempted to explain these findings in socio-cultural terms. It is clear that groups may have their own attitudes toward drinking and drunkenness and a different availability of suitable substitutes for alcohol as a social drug. These and many other attitudinal factors in the social group as a whole, and especially within the family as a nuclear group, may well influence not only the incidence of alcoholism, but its prevention as well. Certainly, such factors are important in affecting group and individual decisions about behavior, but there is no real clarity, currently, as to what extent these factors influence the emergence of so complicated a phenomenon as alcoholism.

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[11] J. A. Ewing and B. A. Rouse, "Report to Special Program on Behavioral Approaches to Alcoholism and Drug Dependence" (University of Washington, Seattle, July 31 - August 1, 1975).

[12] Selden Bacon, Alcoholics Do Not Drink (Annals of the American Academy of Political and Social Science, January 1958), pp. 55-64.

What is more likely is that the illness represents a response to a multitude of determinants of a constitutional (genetic), physiological, psychological, and socio-cultural nature. In any one individual, one or another set of factors may be of weightier influence, but probably all of them must be present in some measure.

At the present, then, the causes of alcoholism are still obscure. The illness is one of a number of other chronic conditions whose etiology is unknown and whose physiological precursors have not yet been uncovered.

Alcoholism is defined as an illness or disease[13] because it is characterized by a recognizable set of symptoms, has a generally predictable course of development, and clearly affects the individual's physical and mental health. In making a diagnosis, neither the quantity alone, the type of alcoholic drink consumed, nor the pattern of drinking is a determining factor. One may drink less than others, in fact, only beer rather than distilled spirits and only on weekends and never in the morning, and still show signs of succumbing to the illness. The evidence for the diagnosis will be seen in the signs of persistent loss of control over drinking and the individual's life being adversely affected.

Treatment

Since the condition of alcoholism is apparently irreversible, there is no known cure. Alcoholism can, however, be treated successfully and arrested at any stage so that literally everyone can be imbued with the hope of stopping the progression of the disease. The single requirement which lies at the basis of recovery is to stop drinking alcohol in any form. The disease process is then arrested and health generally can be restored in a relatively short space of time.

In some alcoholic persons, however, other diseases may also be present independently or be associated with alcoholism. These illnesses may result directly from the repeated assault of alcohol toxicity on the various organ-systems or indirectly through nutritional deficiencies and lowered resistance. Thus, the liver, the stomach and intestines, the heart, the blood vessels and the blood, the brain and peripheral nerves, the muscles and bones, the skin, and every other organ may be affected. If found early, however, and treatment is instituted, no lasting damage due to alcohol is usually seen if abstinence is maintained.

Acute Detoxification

Since the time of Noah and probably before, nonalcoholic individuals who were simply acutely intoxicated on occasion have "slept it off" without any apparent bodily damage.

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[13]Criteria Committee, National Council on Alcoholism, Criteria for the Diagnosis of Alcoholism (American Journal Psychiatry, August, 1972), pp. 127-135.

The pain of their "hangover" passes relatively quickly, and even the central nervous system disorganization and the gastric disorder after a drinking party will achieve physiological equilibrium within a week or so after the alcohol has been oxidized and removed from the body. In some alcoholic persons, however, for reasons unknown, sudden abstinence or even "tapering off" can produce dramatically different results. Here, the withdrawal syndrome, referred to earlier, may involve the "shakes" or tremors, sweating, nausea, intense anxiety, and proceed even to delirium tremens. This latter condition may be characterized further by extreme agitation, hallucinations, confusion and disorientation, convulsions, and, in a significant number of individuals, death. Medical attention can be lifesaving and may require the administration of anti-convulsant and sedative drugs in addition to supportive nursing care.

Relapse

Once the acute condition is alleviated through detoxification, the alcoholic individual must be confronted with the reality of his or her chronic disease and with the need to remain abstinent. In most cases, the individual will need help to maintain sobriety, but relapse or exacerbation may be part of the nature and history of this illness. This is true in the case of many chronic diseases where "attacks" or "flare-ups" recur, such as in arthritis, diabetes, coronary disease, and others. A "slip" by an alcoholic individual must not be regarded as a "failure," but as a renewed challenge for that individual to discover more constructive substitutes for alcohol and a more effective way of life. However, a slip or relapse can be a meaningful learning experience.

Rehabilitation

Fortunately, treatment methods are almost universally available now and show a high rate of effectiveness particularly when combined and coordinated into a comprehensive system. Here, tribute must be paid to Alcoholics Anonymous which is perhaps the most effective single agency in the constellation and which, since its founding in 1935, has pursued the concept that alcoholism is a multi-factorial illness.[14] When the professional health care provider can evaluate the nature of the alcoholic patient's needs and expose him to Alcoholics Anonymous as a new way of life without alcohol, and confront him at the same time with his own responsibility for utilizing any or all of the variety of appropriate treatment modalities available—medical, psychological, nutritional, recreational, spiritual, social, and many others—an astonishingly high percentage of alcoholic persons is seen to recover. Almost miraculously, they begin to live constructively—a vastly different existence from their former alcohol-clouded life. In the process of change, almost every category of professional "helper" and "gate-keeper" in society may be able to play a significant role—the physician and nurse, the psychotherapist and clergyman, the social worker and counselor, the police, the judge and correctional officer, the teacher and friend, and the employer and labor union official.

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[14]Alcoholics Anonymous, Alcoholics Anonymous (New York: Alcoholics Anonymous World Services, Inc. 1955).

Alcoholism is also a truly "family disease" in the sense that the alcoholic member always has a profound and destructive effect on the spouse, the children, the parents, and other relatives. In turn, he is deeply influenced by the attitudes and behavior of those family members who are not affected by alcoholism. The Al-Anon program, an offshoot of Alcoholics Anonymous, plays a useful role in treatment by focusing on helping—often with a positive side-effect on the alcoholic family member—the non-alcoholic member(s).

Particular success has been achieved in programs which encourage motivation for treatment by confronting the alcoholic individual with an inescapable, unpleasant alternative. Thus, when the person is threatened with job loss if his performance on the job continues to deteriorate, and when both labor and management cooperate in providing an opportunity for treatment without penalty, a high rate of recovery from alcoholism occurs. Motivational programs in industry and the military services have reported success as high as 75 percent and more.[15, 16]

A somewhat similar approach has been taken by the federal government in the Alcohol Safety Action Program (ASAP) of the Department of Transportation (DOT).[17] Alcohol consumption plays a role in 50 percent of the estimated 60,000 highway deaths each year. Of these 30,000 driver and pedestrian fatalities, probably 20,000 are "problem drinkers" who not only consume too much alcohol, but have had previous problems because of their use of alcohol. These problems take the form of other arrests or contact with a social agency or medical care such as hospitalization involving alcohol abuse. The DOT program attempts to single out these drivers from the great mass of social drinkers who drive. The ASAP approach is designed to insure that this category of drivers does not get back on the highway without undergoing treatment for alcoholism. Through ASAP, cooperation of the driver may be secured by offering him the opportunity to regain a revoked driver's license or by limiting, but not revoking, driving privileges when he accepts responsibility to abstain from alcohol.

Attitudes

Unfortunately, the clear potential for success in the overall treatment, control, and prevention of alcoholism has not yet been realized, and one may well ask, "Why?" Across the country, the number of persons being treated for alcoholism is a pitifully small fraction of the total of those who suffer from the illness. In the past, society

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[15]National Council on Alcoholism, "Postal Service Keeps Up with PAR," Labor-Management Alcoholism Newsletter, Vol. 2, Sept., Oct., 1972.

[16]Department of Health, Education and Welfare, National Institute on Alcohol Abuse and Alcoholism, "The Navy Fights Alcoholism, in Alcohol, Health and Research World," Fall, 1973.

[17]G. J. Driessen, and J. A. Bryk, "Alcohol Countermeasures: Solid Rock and Shifting Sand," Alcohol, Drugs, and Driving (Washington, D.C.: National Highway Traffic Safety Administration, Technical Report, DOT HS-801-096, 1974).

has tended to place responsibility for this situation on the so-called lack of motivation of the alcoholic persons themselves. This explanation, however, is refuted by the way in which facilities having good treatment services are filled to capacity and even oversubscribed almost as soon as they are opened. A task force of the National Institute on Alcohol Abuse and Alcoholism has called attention to the "serious deficit of such services." As a result, "Only a small portion of alcoholic people are receiving the services they require. Moreover, the bulk of treatment services which are available are designed for late-stage alcoholism and do not meet the needs of people in earlier identifiable stages of the illness."[18]

The resistance of individuals afflicted with alcoholism to enter treatment, even while denying the reality of their illness in spite of intense pain, stems not from any lack of desire to get well. Mostly, their opposition is a reflection of the attitudes and behavior of the society surrounding them.

Physicians, nurses, social workers, clergymen, as well as professionals in other disciplines who treat every other kind of illness in our health care and social service system may nevertheless reject the individual suffering from alcoholism. Even where public drunkenness is no longer a crime and the police, recognizing that the sick alcoholic in the street needs help, transport such a person to a hospital, the individual concerned may yet experience discrimination at the medical facility or be denied admission and treatment. Small wonder, then, that some people conclude erroneously that the alcoholic person who has committed no crime might be better off in jail!

A number of societal attitudes must become deeply rooted to insure appropriate handling of the problems associated with alcohol use. First, and perhaps foremost, must be the conviction that, in the broadest sense, alcoholism is an illness in which every health and social agency can and must play a role. Intoxication is a symptom of that illness and must not be encouraged or condoned as an object of ridicule or amusement.

Second, alcoholism cannot and must not be regarded as a self-inflicted illness. The person who succumbs to this sickness is no more responsible for this diagnosis than is the diabetic for diabetes. In both cases, the illness was not deliberately or willfully acquired. Responsibility for the illness must clearly be separated from the responsibility for treating it. Again, in both instances, the individual must be confronted with his or her personal responsibility for maintaining the prescribed "diet" and participating in whatever treatment regimen is necessary to prevent the signs and symptoms from recurring. For someone to encourage a sense of guilt in the alcoholic about being an alcoholic person or even to overlook the existence of such guilt, which almost all alcoholic persons experience, will often precipitate a relapse. When guilt and anxiety rise to intolerable levels, alcohol can and does produce temporary surcease from tension and pain, and the therapist as well as society must be aware of this shared responsibility.

[18] Ibid.

Third, there is a deeply ingrained attitude that alcoholism is a hopeless illness. Nothing could be further from the truth. This feeling stems from our failure to recognize the illness of alcoholism at any other than near the terminal stage, i.e., when we observe the skid-row denizen. Not only is there the striking evidence just presented concerning the high rates of recovery when the illness is treated early, but there are also those regarded previously as "hopeless" or "brain damaged" who have been able to stop drinking. With appropriate treatment, they have been able to maintain sobriety, return to a healthier living pattern, responsible social functioning, and gainful employment.

Finally, the attitude which leads only to treating the casualties of alcoholism, and then only the later-stage victims just discussed, must be vigorously uprooted. With it should go the attitudes which relate to the kind of irresponsible and destructive drinking behavior which places the individual in a high risk group and is carried contagiously from the adult world to that of the young. Instead, society must explore the means of encouraging responsible decisions about drinking beverage alcohol; whether or not to do so at all; and if so, why, what, when, where, how, with whom, and how much. Only then will an illness so vast and so devastating in its consequences come under control. Fortunately, the opportunity to do so is now at hand. All that remains is for responsible individuals to recognize and assume this obligation.

CHAPTER II

II

DECRIMINALIZATION AND THE UNIFORM ACT

Background

As a group, the police may have been the first to take up the massive role of attempting to do something about the ills of society, to keep order, and to help their fellowman. In the broadest sense, this statement rings true, but its verbalization may invoke disagreement even among police officers. Nevertheless, when the character of their work is carefully analyzed, most police officers will agree that they spend so much time dealing with "nonpolice" matters—acts that are not essentially criminal—that they have little time for anything else.

Any discussion about "crime," however, must consider that the designation of an act, its omission or compliance with it, as outlined in law, merely reflects the attitudes, customs, and beliefs of the society. These requirements vary from social group to social group, from culture to culture, and from state to state. Moreover, the passage of time frequently influences how a particular society views or reacts to "crime."

History reflects many inconsistencies in what is considered to constitute "crime;" and, in other examples, an act or behavior pattern previously identified as "criminal" has been reversed and accepted as normal practice. The repeal of the Volstead Act (Prohibition) in 1933 is a striking example of a practice freely accepted prior to 1919; made a crime, prohibited by law nationwide, from 1919 to 1933; and then repealed in 1933. Apart from such dramatic instances, judicial and enforcement practices have also influenced the meaning of "crime." But perhaps these, too, are only reflections of changes in the society.

Early References to Alcohol

References to alcohol exist in antiquity. Anthropological studies make reference to the consumption of alcoholic beverages in most of the preliterate cultures.[1] The long history of alcohol and its existence through numerous cultures and societies disclose an almost lengthy parallel in efforts to control its use.

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[1]Clarence H. Patrick, Alcohol, Culture, and Society (Durham: University of North Carolina Press, 1952), Chapter 2.

Patrick writes that as early as 2000 B.C., a Chinese emperor is said to have banished an individual who discovered a method of making wine...in India (200 B.C. - A.D. 200), the Law of Manu declared that a person drinking "sura" (a spirituous liquor) was to be excluded from all fellowship at meals...and matrimonial allegiances, and religious duties...in the year 1279, the Mongol emperor, Kublai Khan, issued an edict condemning dealers in alcoholic beverages to banishment and slavery.[2]

In the early history of the New World, Usher notes that, though the Pilgrim fathers brought with them on the Mayflower a generous supply of alcoholic beverages, excessive use of alcohol had almost always been defined as criminal.[3] In the Colonies in 1633, one Robert Cole, a citizen of the Massachusetts Colony, having been frequently punished for drunkenness, was ordered to wear a red "D" about his neck for a year.[4]

Drunkenness as a Crime

With this heritage in mind, it is easy to see that throughout the existence of this country, at least until the 1960s, a sort of criminal tinge was associated with alcohol abuse. The common offense was generally simply defined as "drunkenness," usually in a public place, but this was interpreted quite literally to mean any place outside of one's home.

Other related forms of statutory offenses included: drunk and disorderly, drinking in public, loitering, vagrancy, panhandling, habitual drunkard, possession of untaxed liquor, and various other measures relating to illegal sale or possession. And, as previously noted, there was a period in our country when the provisions of the 18th Amendment to the Constitution were applied throughout the land in a massive, unsuccessful attempt at prohibition.

Civil Process

In another vein, many states enacted various forms of civil process and authority to handle and treat alcoholic persons. Most of these were similar to those provisions that dealt with mental cases and provided for some type of custody or commitment of individuals in need of treatment for alcoholism

Under civil authority, voluntary commitment was also possible in some public facilities; however, individuals who availed themselves of such commitment were frequently permitted to "sign themselves out" following detoxification. Private facilities also existed for the exclusive treatment of those afflicted with alcoholism, many under the guise of "rest homes" or other innocuous names. In these instances, although legal authority could be and often was employed, sanction was more frequently invoked by the family or close relatives of the patient.

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[2]Ibid.

[3]Roland G. Usher, The Pilgrims and Their History (N.Y., Macmillan, 1930).

[4]Patrick, op. cit.

As it became more evident that alcoholism was an illness, some farsighted officials began to investigate the criminal process for dealing with drunk offenders. Police began to streamline arrest and booking procedures, court officials commenced to seek alternate sentencing measures, and custodial practices were reexamined to permit a more humane detoxification effort. This gradual awareness and acceptance was stimulated, rather dramatically, by a number of events which occurred in 1966.

Attitudes and Practices Impacting on Chronic Alcoholism Prior to 1966

The sustained efforts of several formal groups and individuals, sufficiently concerned about the problems associated with alcohol abuse and alcoholism, have resulted in significant changes in community responses to these problems. The persistent struggle of many social service and health agencies, Alcoholics Anonymous, and concerned individuals has been to remove the predominant stigma of social degeneracy generally associated with alcoholism and to promote recognition of alcoholism as a disease. Success in achieving desirable results has been slow, but encouraging inroads have been made. Progress is evident in the degree to which a significant portion of the general public has come to accept alcoholism as a disease (if not in a de facto at least in a de jure sense). The impact of this effort is most evident in the relatively recent response by legislators and judicial tribunals.

To continue in the achievement of desired goals will necessitate a strong effort and determination in the face of overt resistance, apathy, and lack of assistance from a significant portion of our society. There is an apparent continuing adherence, among the general public, to the philosophy that alcoholism is an indication of degeneracy and character defect. Among those who do accept alcoholism as a disease are some who view it as being self-inflicted and have little empathy with the victim. The negative stigma socially associated with alcoholism, particularly that attached to the indigent, is apparent to the most casual observer. The degree to which these prevailing negative attitudes are overcome will influence, to a large extent, the success achieved in diverting alcoholic persons from the criminal justice system.

Prior to 1966, drunkenness had been made a criminal offense in most police jurisdictions in the Nation and was punishable under a variety of laws. This resulted in the criminal justice system being overloaded with cases involving alcohol abuse. There was a large recidivist rate, and many of the repeat offenders were suffering from chronic alcoholism. Typically, the indigent alcoholic individual and his peers inhabited an area of a city which had become, to a degree, tolerant of their behavior and life style.

Role of the Police. The police arrested drunk individuals when the behavior or appearance of an inebriate exceeded the tolerance usually acceptable in the community and when one or more of the variety of existing laws and/or ordinances was violated. The police had broad discretion in determining when to make an arrest or when some other action was indicated. In many cases, the subject was taken home by the officer, released in the custody of responsible persons, ignored, told to go home, or placed in a taxi and sent home. In most instances, no formal record of the incident

was made. Police discretion in these cases was usually influenced by the nature of the drunken person's behavior (violent, passive, cooperative); laws, other than drunkenness, that had been violated; whether the person had a home or place to go; the presence of another person capable of assuming responsibility for the drunk; environmental conditions (extreme heat or cold); traffic conditions which presented a threat to the incapacitated person; and geographic location (level of acceptance of this behavior in the neighborhood). In the more progressive police agencies, administrative policies provided discretionary guidelines for the officers' consideration.

Generally, police officers perceived their role in enforcing alcohol-related laws and the handling of public inebriates as one of their less important functions. There was a predominant feeling among police officers that arresting drunks served no useful purpose. This attitude prevailed due to the overall impact of the criminal justice system on the problems associated with alcoholism and alcohol abuse. Typically, arrested persons were transported to jail, arraigned before a judge, sentenced to a brief stay in jail or nominal fine, released upon completion of the sentence or payment of the fine, and returned to the same environment. This cycle, often involving the same individuals, was repeated many times and soon became known as the "revolving door."

The overall effect of this system on the participants had a negative impact at every level. The police became apathetic to the social problem and became frustrated at what they looked upon as a futile effort. In many jurisdictions, teams of police officers were assigned to patrol in "paddy wagons," making periodic "sweeps" in those areas where the violations were predominant, to pick up those who were incapable of caring for themselves. The problem was handled from the perspective of having to deal with groups of persons which resulted in less attention being given to individual needs.

Role of the Courts. In large jurisdictions, the courts were overloaded with cases involving drunkenness and were forced to adjust procedures to handle the volume. In some courts, persons entering guilty pleas were grouped into one area of the courtroom and adjudged en masse. Those who intended to plead not guilty were likewise assembled, and their cases postponed until time could be allocated for a hearing.

In this system, those who contested their cases were often held in confinement longer than those who entered guilty pleas. Thus, the process encouraged a plea of guilty for those individuals interested in regaining their freedom. The lack of attention to individuals coming before the court, the backlog of cases creating delays in trials, and the "hurried" courtroom procedures served to create a negative attitude toward the courts among the defendants.

Role of Corrections. Under the procedures just described, jails across the Nation were literally filled with indigent alcoholics. Jail supervisors and guards were provided little resources for the treatment of these individuals. In effect, the jails served as places for drunks to sober up and receive temporary housing, meals, and limited medical care. As poor as these jail conditions were, in many cases they represented improved living conditions for the chronic and indigent alcoholic person.

The Medical Services. Medical services under this system were usually limited to emergency treatment of conspicuous injuries, unconsciousness, or persistent symptoms of serious illness. City and county physicians in some jurisdictions made periodic visits to the jails to attend to medical problems. These physicians were usually paid by the local government with limited budget allocations for medication and supplies. The treatment of patients under these circumstances was temporary and oriented more toward relieving symptoms than curing the illness. As limited as this treatment was, it is interesting to note that many impoverished inebriates used a jail sentence as a means of obtaining even this small amount of medical attention.

The recognition of alcoholism as a disease made significant inroads into the legislatures and the criminal justice system in the 1960s. Progress in this regard was very limited until 1966 when certain landmark judicial decisions relating to alcoholic intoxication were announced and, in turn, forced numerous changes in our legal and social systems.[5] Summarizing the attitude of the courts prior to 1966, the President's Commission on Law Enforcement and Administration of Justice has this to say in its Task Force Report: Drunkenness:

> ...a chronic alcoholic was held criminally responsible for being intoxicated in public, as well as for any other antisocial conduct caused by his drinking, even though that intoxication and resulting conduct were the involuntary and unavoidable products of his alcoholism. In only one reported decision was this general rule rejected. In the case of State v. Pike, decided in 1869, the defendant was charged with murder. The New Hampshire Supreme Court held that if the defendant could prove that alcoholism were a disease and that the murder was the product of his alcoholism, he could not be held criminally responsible for it. But the Pike decision stood alone for almost a century.[6]

As indicated, the question of appropriate legal and social response to alcoholism and related criminal offenses has prevailed for many years. Even the case of State v. Pike in 1869 had little influence on the criminal justice system in its handling of those affected with chronic alcoholism.

Factors Affecting Diversion of Chronic Alcoholic Persons from the Criminal Justice System

Alcoholism as a Disease. For many years, alcohol abuse has been appraised as deviant behavior in violation of criminal laws and ordinances. In the early 1950s,

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[5]These decisions are discussed later in this chapter and in Appendix F.

[6]The President's Commission on Law Enforcement and Administration of Justice, Task Force Report: Drunkenness (Washington, D.C.: U.S. Government Printing Office, 1967), p. 110.

there was an attempt to reevaluate this appraisal from the perspective of alcoholism as a disease. A pioneer in this effort was the late Dr. E. M. Jellinek who devoted many years of his life to writing about, researching, and teaching the theory of alcoholism as a disease.

Dr. Jellinek recognized and distinguished specific phases of alcohol addition. These phases of addiction and symptoms characteristic of each phase are described as follows:

Purely Symptomatic Phases

Prealcoholic Phase

- Occasional relief drinking
- Constant relief drinking

Prodromal ("Forerunner") Phase

- Alcohol palimpsests ("blackouts," amnesia)
- Surreptitious drinking
- Preoccupation with alcohol
- Avid drinking
- Guilt feelings about drinking behavior
- Avoidance of reference to alcohol
- Increasing frequency of alcoholic palimpsests

Addictive Phases Superimposed over Symptomatic Drinking

The Crucial Phase

- Loss of control
- Rationalization of drinking behavior
- Drinking to counter social pressures
- Grandiose behavior

- Marked aggressive behavior
- Persistent remorse
- Periods of total abstinence
- Changing patterns of drinking
- Dropping friends
- Quitting job
- Entire behavior becomes alcohol-centered
- Loss of outside interests
- Reinterpretation of interpersonal relations
- Marked self-pity
- Geographic escape
- Change in family habits
- Unreasonable resentments
- Protection of alcohol supply
- Neglect of proper nutrition
- Hospitalization
- Decrease of sexual drive
- Alcoholic jealousy
- Regular matutinal (morning) drinking

The Chronic Phase

- Prolonged intoxications
- Marked ethical deterioration
- Impairment of thinking
- Alcoholic psychosis
- Drinks with persons far below social level

- Recourse to "technical products"
- Loss of alcohol tolerance
- Indefinable fears
- Tremors
- Psychomotor inhibition
- Drinking takes on an obsessive character
- Vague religious desires develop
- Rationalization system fails[7]

The most cursory review of the phases and characteristic symptoms identified by Dr. Jellinek reflects physiological, psychological, sociological, and spiritual ramifications of the disease of alcoholism. This early effort of symptomatic identification has stimulated interest among these several disciplines resulting in significant inroads into the recognition of alcoholism as a disease and its subsequent treatment.

Among these inroads has been the recognition that handling, in the sense of treating, alcohol abusers within the criminal justice system has been relatively unsuccessful. This general acknowledgment has brought about substantial changes in many states in the treatment of alcohol abusers in the criminal justice system.

Appellate Court Decisions. (A substantial portion of this section is based on information contained in the First Special Report to the U.S. Congress on Alcohol and Health, from the Secretary of Health, Education and Welfare, published in 1971.

The acceptance of alcoholism as a disease progressed rapidly from the mid-1950s through the mid-1960s. The promotion of this concept by several special-interest groups was developed during a time of exceptional public awareness of sociological problems, particularly those associated with the criminal justice system. During this period, probation and parole programs experienced rapid growth, release of persons arrested on personal recognizance was emphasized, and the U.S. Supreme Court made several landmark decisions having dramatic impact on the criminal justice system.

Among the major decisions emerging from appellate courts during the 1960s, two addressed the diversion of persons suffering from chronic alcoholism from criminal proceedings. As stated by Peter Barton Hutt in Appendix H of Task Force Report: Drunkenness:

[7]Simon Dinitz, Russell R. Dynes, Alfred C. Clarke, Deviance-Studies in the Process of Stigmatization and Societal Reaction (New York: Oxford University Press, 1969), pp. 251-263.

> In March 1966 the United States Court of Appeals for the District of Columbia Circuit, sitting en banc in the DeWitt Easter case, unanimously held that a chronic alcoholic cannot be convicted for his public intoxication. That decision, together with the Fourth Circuit's similar decision in the Driver case, represent an urgent mandate to take the problem of the chronic inebriate out of the criminal law, and to handle it from now on under public health, welfare, and rehabilitation programs.[8]

The decision of the U.S. Court of Appeals in the Easter decision is presented here to reflect the logic of the court at the time of this decision. The appellate court decision begins by citing the judges who concur or dissent on the issue at bar, presents a brief background on the lower court decision, cites the Code in question, and presents a concise statement on the defense as follows:

EASTER v. DISTRICT OF COLUMBIA
361 F.2d 50 (D.C. Cir. 1966)

> Fahy, Circuit Judge, with whom Bazelon, Chief Judge, and Wright and Leventhal, Circuit Judges, join and with whom McGowan, Circuit Judge, joins in the result and in Parts I and III of the opinion.
>
> In the Court of General Sessions of the District of Columbia, at a trial by a judge without a jury, appellant DeWitt Easter was found guilty of having been "drunk and intoxicated" on a stated date in a street in Washington, in violation of our Code provision reading:
>
> > No person shall...be drunk or intoxicated in any street, alley, park, or parking;...
>
> D.C. Code §25-128(a). He was given a suspended sentence of ninety days imprisonment. That he was drunk or intoxicated at the time and place stated was proved and was uncontested. His defense was that he was a chronic alcoholic.
>
> The judge did not rule that the evidence fell short of establishing that appellant was a chronic alcoholic. The judge ruled that the evidence to that effect was not pertinent; that is, that chronic alcoholism was not a defense to a charge of intoxication in a public place.

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[8]The President's Commission on Law Enforcement and Administration of Justice, op. cit., p. 109.

The District of Columbia Court of Appeals affirmed the conviction. Easter v. District of Columbia, D.C. App., 209 A.2d 625.

We allowed an appeal to this court. Sitting en banc we heard and now decide the case.

In Part I, a concise statement of the court's decision is presented:

I

Our decision is that chronic alcoholism is a defense to a charge of public intoxication and, therefore, is not a crime in violation of Section 25-128(a) of our Code, supra n. 1. We think this follows, in the first place, from the Act of Congress of August 4, 1947, entitled "Rehabilitation of Alcoholics," 61 Stat. 744, c. 472, now embodied in our Code as Sections 24-501 et seq.

In aid of its purposes, one of which is "to establish a program for the rehabilitation of alcoholics, promote temperance, and provide for the medical, psychiatric, and other scientific treatment of chronic alcoholics" the Act provides,

> the courts of the District of Columbia are hereby authorized to take judicial notice of the fact that a chronic alcoholic is a sick person and in need of proper medical, institutional, advisory, and rehabilitative treatment, and the court is authorized to direct that he receive appropriate medical, psychiatric, or other treatment as provided under the terms of this chapter.

D.C. Code § 24-501 (1961 ed.).

A "chronic alcoholic" is defined in the Act:

> The term "chronic alcoholic" means any person who chronically and habitually uses alcoholic beverages to the extent that he has lost the power of self-control with respect to the use of such beverages, or while under the influence of alcohol endangers the public morals, health, safety, or welfare.

D.C. Code § 24-502 (1961 ed.).

The rationale of the court with respect to mens rea is expressed at this point:

> We are concerned in this case only with that part of the above definition which refers to loss of the power of self-control with respect to the use of alcoholic beverages.
>
> The above statutory provisions, considered in the full context of the Act of which they are a part, preclude attaching criminality in this jurisdiction to intoxication in public of a chornic alcoholic. An essential element of criminal responsibility is the ability to avoid the conduct specified in the definition of the crime. Action within the definition is not enough. To be guilty of the crime a person must engage responsibility in the action. Thus, an insane person who does the act is not guilty of the crime. The law, in such a case based on morals, absolves him of criminal responsibility. So, too, in case of an infant. In case of a chronic alcoholic Congress has dealt with his condition so that in this jurisdiction he too cannot be held to be guilty of the crime of being intoxicated because, as the Act recognizes, he has lost the power of self-control in the use of intoxicating beverages. In his case an essential element of criminality, where personal conduct is involved, is lacking.

The disparity of the Code in question regarding the private and public manifestation of alcoholic intoxication, is then addressed by the court:

> It is suggested that the public nature of the intoxication adds a factor which precludes the defense-that if suffering from the sickness is not manifesting it in a public place is. But nothing whatever indicates that Congress intended to limit the scope of the Act to persons sick in privacy. It is clear the Act was primarily concerned with persons found in public places. The provisions which contemplated their institutional care, instead of the jail, show indubitably that the non-criminal approach of Congress applied to the chronic alcoholic floundering in a public place. The lack of power of self-control referred to cannot be limited to absolution of criminality for drinking or being drunk in a non-public place. No statute in the District of Columbia makes such an act or circumstance criminal. The very nature of the sickness goes where its victim goes.

The appellate court then makes note of its acceptance of the Rehabilitation of Alcoholics Act passed by Congress in 1947:

> We find no basis for judicial repudiation of the Act of 1947. The fact that in the intervening years the facilities contemplated by the Act have not been made available does not detract from the legal effect of those provisions of the Act which define the nature of the sickness.

> One who has committed no crime cannot be validly sentenced as a criminal because of a lack of rehabilitative and caretaking facilities.
>
> In event of a determination of chronic alcoholism under the procedures of D.C. Code § 24-504 commitment for treatment is not mandatory. In the judge's discretion the accused may be released. But he may not be punished.

In Part II of the decision, the appellate court cites a parallel decision in a habeas corpus proceeding before the Court of Appeals for the Fourth Circuit in Driver v. Hinnant. The court also limits the decision as applicable only to chronic alcoholism, i.e., the involuntary drinker.

II

> Our decision would be the same were we without the guidance furnished by the Act of 1947. One who is a chronic alcoholic cannot have the mens rea necessary to be held responsible criminally for being drunk in public.
>
> The same basic problem now before us was recently before the Court of Appeals for the Fourth Circuit in Driver v. Hinnant, 356 F.2d 761. This was a habeas corpus proceeding attacking in the federal courts a conviction of Driver of public intoxication by the courts of North Carolina. Under a State statute it was a misdemeanor to be found "drunk or intoxicated on the public highway, or at any public place or meeting." Even without benefit of such a statute as our Act of 1947, the court sustained the defense of chronic alcoholism. The court said in part:
>
> > It is known that alcohol can be addicting, and it is the addict-the involuntary drinker-on whom our decision is now made. Hence we exclude the merely excessive-steady or spree-voluntary drinker.
> >
> > This addition-chronic alcoholism-is now almost universally accepted medically as a disease. The symptoms, as already noted, may appear as "disorder of behavior." Obviously, this included appearances in public, as here, unwilled and ungovernable by the victim. When that is the conduct for which he is criminally accused, (t)here can be no judgment of criminal conviction passed upon him. To do so would affront the Eighth Amendment, as cruel and unusual punishment in branding him a criminal, irrespective of consequent detention or fine.

28

> Judge Bryan also stated for the court that Robinson v. State of California, 370 U.S. 660, "sustains, if not commands, the view we take." In Robinson the Supreme Court held invalid as cruel and unusual punishment prohibited by the Eighth and Fourteenth Amendments a California statute which made drug addiction a crime. The Court said such addiction was a status involuntarily assumed, and therefore to punish it as a crime violated the constitutional provisions.
>
> We close this discussion with the observation that confinement, e.g. for inquiry or treatment, lies within the means available for dealing, constitutionally, with a menace to society.

Part III of the court's decision concludes that the lower court received sufficient evidence of the defendant's chronic alcoholic condition, and therefore reversed the lower court's decision by using the following language:

> III
>
> It follows that the evidence of chronic alcoholism adduced in this case was pertinent. It established the defense.
>
> Expert medical and psychiatric evidence, not sought to be rebutted, proved that appellant was a chronic alcoholic who had lost self-control over his use of alcoholic beverages. His condition, with its usual physical manifestations, was arrayed fully before the trial judge and need not be repeated here in detail. Since 1937 appellant has been arrested for intoxication or associated conduct 70 times, 12 times in 1963 alone. On innumerable occasions he has been intoxicated but not arrested. The condition had progressed for many years, definitely since the 1930s, resulting in a broken home life, recurrent hospitalization, and loss of steady employment.
>
> Reversed, with direction to remand to the Court of General Sessions for dismissal of the information.[9]

[9]Frank F. Remington, Donald F. Newman, Edward L. Kimball, Marygold Melli, and Herman Goldstein, Criminal Justice Administration Materials and Cases (New York: The Bobbs-Merrill Company, Inc., 1969), pp. 1232-1236.

Accordingly, "In Driver v. Hinnant, the U.S. Court of Appeals for the Fourth Circuit—which includes the States of Maryland, Virginia, West Virginia, North Carolina, and South Carolina—held that to convict a chronic alcoholic for public intoxication, and thus to ignore the common law principle followed in the Easter decision, violates the prohibition against cruel and unusual punishment contained in the Eighth Amendment to the United States Constitution."[10]

In both the Easter and Driver cases, it is important to recognize the defendants did not initiate the appeals themselves. DeWitt Easter had been arrested more than 70 times since 1937, and was an indigent, homeless, chronic alcoholic. The Easter case represents the fifth attempt in the Washington, D.C. courts to initiate appeal procedures to obtain an appellate court ruling on these cases for the purpose of establishing the principle that alcoholism is a disease, and that public intoxication is properly handled as a public health, welfare, and rehabilitation problem. The four previous attempts failed due to the prosecution dropping charges against the defendants. The court intervened and forced a discontinuation of this practice.

Likewise, Joe Driver's record of arrests for public intoxication contains over 200 entries, and Driver had spent more than two-thirds of his adult life in jail. Driver was also a homeless, indigent, chronic alcoholic who happened to be chosen for an appeals case impacting on the treatment of alcoholics.[11]

These two cases were appealed to initiate reform in the treatment of alcoholic persons. Total reform, however, cannot be left entirely to the courts. The courts' decisions dealt with the punishment of the offenders, but did not change existing legislation or establish an alternative system for handling these persons. The limitations of the appellate court decisions are clearly stated in the Task Force Report: Drunkenness as follows:

> These appellate decisions do not, however, spell out how this mandate is to be implemented. An appellate court cannot inject the actual substance of justice into the lives of each of the derelict inebriates who daily come before the Nation's criminal courts.[12]

In view of the Easter and Driver cases and the public sentiment and awareness of alcoholism as a disease, it was anticipated that when the appropriate case arose, the

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[10]The President's Commission on Law Enforcement and Administration of Justice, op. cit.

[11]Department of Health, Education, and Welfare, First Special Report to the U.S. Congress on Alcohol and Health (Washington, D.C.: Government Printing Office, December, 1971), p. 85.

[12]The President's Commission on Law Enforcement and Administration of Justice, op. cit.

U.S. Supreme Court would rule similar to the lower appellate courts. However, in June 1968, in Powell v. Texas the U.S. Supreme Court upheld a lower court's conviction for public intoxication. The majority opinion of the court may be found in Appendix F to this manual.

Leroy Powell was also an indigent alcoholic with a long record of convictions for public intoxication. In interpreting the Court's decision, it is important to study the several opinions of the Court. In brief, the case was decided by a 5 to 4 decision. Eight of the justices were split on the issue; Justices Marshall, Warren, Black, and Harlan expressed the opinion that the "revolving door" system was aimless, but the application of new medical knowledge should not be hardened into rigid constitutional principles, but left to the states. Justices Fortas, Brennan, Douglas, and Stewart concurred that imposing criminal penalties for public intoxication would violate the Eighth Amendment, consistent with the Driver decision. The deciding vote was cast by Justice White. In a separate opinion, Justice White recognized the reasoning of the other views, but perceived the controlling issue in the Powell case to center on the issue of being intoxicated in public. There was no evidence that Powell could not avoid being in public on the occasion on which he was arrested. Mr. Justice White voted to confirm the conviction.[13] Mr. Justice White's opinion is expressed as follows:

> Thus, the deciding vote was cast by Mr. Justice White. In a separate opinion, he concurred both with the reasoning expressed in the opinion of Mr. Justice Fortas, and with the disposition of the case expressed in the opinion of Mr. Justice Marshall. In Justice White's view, the controlling issue was whether Powell could avoid being intoxicated in public. Because there was no evidence that Powell could not avoid being in public on the occasion on which he was arrested, Mr. Justice White voted to affirm the conviction. At the same time, however, he recognized that homeless derelict alcoholics suffer from a disease and could not properly be convicted for their public intoxication:
>
> > The fact remains that some chronic alcoholics must drink and hence must drink somewhere. Although many chronics have homes, many others do not. For some of these alcoholics I would think a showing could be made that resisting drunkenness is impossible and that avoiding public places when intoxicated is also impossible. As applied to them this statute is in effect a law which bans a single act for which they may not be convicted under the eighth amendment - the act of getting drunk. It is also possible that the chronic alcoholic who begins drinking in private at some point becomes so drunk that he loses the power to control his movements and for that reason appears in public. The

[13]Department of Health, Education and Welfare, op. cit., pp. 86, 87.

> eighth amendment might also forbid conviction in such circumstances, but only on a record satisfactorily showing that it was not feasible for him to have made arrangements to prevent his being in public when drunk and that his extreme drunkenness sufficiently deprived him of his faculties on the occasion in issue. 392 U.S. at 551-552.[14]

Thus, a review of the opinions expressed by the United States Supreme Court Justices in Powell v. Texas does not reflect a contradiction to the lower appellate courts in Easter and Driver; merely that sufficient evidence was not reflected in the Powell case to justify a reversal.

Presidential Task Force Reports. President Johnson appointed two crime commissions in 1965. One was to conduct a national survey of law enforcement and administration of justice; the other to study crime in Washington, D.C. Following the Easter decision in 1966, both crime commissions conducted an extensive review of the handling of intoxication and alcoholism under criminal law.

Both commission reports were released in 1967. The recommendations included in the reports, with regard to public intoxication, closely parallel each other. Each of the commissions recommended elimination of public intoxication as a criminal offense and the substitution of public health, welfare, and rehabilitation measures to handle the problem.[15] These recommendations served to enhance the recent appellate court decisions.

State Legislation. The influence of the acceptance of the disease concept to alcoholism, the appellate courts, and the Presidential Task Force Reports had a significant impact upon state legislative bodies. Many states, including North Carolina, Hawaii, Maryland, North Dakota, Connecticut, Florida, and Massachusetts, as well as the District of Columbia passed legislation reflecting general acceptance of these standards. Many other states initiated considerations oriented in the general direction of the Task Force recommendations. In this regard, the National Institute on Alcohol Abuse and Alcoholism has undertaken a major role in encouraging and assisting states and local jurisdictions in adopting a consistent pattern of legislation.

Development of the Uniform Act. Following the crime commission reports, three separate teams proceeded to draft model or uniform legislation governing intoxication and alcoholism. These teams included:

- The American Bar Association—American Medical Association Joint Committee on Alcoholism

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[14] Ibid., p. 87.

[15] Ibid., p. 89.

- The Columbia University Legislative Drafting Research Fund Model

- The National Conference of Commissioners on Uniform State Laws

The ABA-AMA Model Law closely paralleled recommendations made in the crime commission reports. In effect, this model repealed the public intoxication offense by adopting a "disorderly intoxication" provision and provided that all intoxicated persons who were not disorderly must be handled under civil detoxification in-patient and out-patient procedures.

The Columbia University Legislative Drafting Research Fund Model simply abolished all criminal offenses relating to intoxication and drinking in public, rather than adopting a disorderly intoxication provision, on the ground that disorderly intoxication was adequately covered by the standard disorderly conduct law. Treatment provisions in this model were similar to those in the ABA-AMA model, but more limited in detail regarding some obvious problems associated with alcoholism and intoxication.

The National Conference of Commissioners on Uniform State Laws Model was adopted as the Uniform Act in August 1971. The National Conference was comprised of representatives appointed by the governor of each state. It was incumbent upon these representatives to obtain the introduction of the Act in their legislatures. A copy of the Uniform Act is included as Appendix B to this manual.

Since the adoption of the Uniform Act by the National Conference of Commissioners on Uniform State Laws, almost half of the states have adopted the Act as law. Additionally, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616) which represented major federal legislation in the area of alcohol abuse and alcoholism and established the NIAAA was amended in 1974 by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (Public Law 93-282). Public Law 91-616 and Public Law 93-282 are reproduced in Appendices C and D, respectively.

The decriminalization of public drunkenness was given further emphasis by the National Advisory Commission on Criminal Justice Standards and Goals in Report on Police. In Recommendation 4.1, the Commission states:

> It is recommended that every State enact legislation that provides authority for civil commitment and diversity of persons who, because of alcoholism or drug addiction, are in need of treatment and who should be dealt with outside the criminal justice system. Legislation should provide funding for treatment centers where such persons can receive both detoxification and followup care.[16]

[16] National Advisory Commission on Criminal Justice Standards and Goals, Report on Police (Washington, D.C.: U.S. Government Printing Office, 1973), p. 90.

The recognition of alcoholism as a disease, recommendations by task forces and commissions, adoption of a Uniform Act, and enabling legislation at the federal, state, and local levels will not produce a magical change in our traditional attitudes and methods of dealing with alcohol abuse and alcoholism problems. However, these recommendations and legislative efforts will provide a means to implement diversionary programs based upon sufficient study and an understanding of the problems associated with handling alcoholism cases within the criminal justice system. A successful diversionary program is dependent upon the establishment of an alternative system, and a thorough understanding by each of the participants in the alternative system of the overall objectives and their proper role and responsibilities in the system.

CHAPTER III

III

THE POLICE AND THE TREATMENT PROGRAM

Treating the public inebriate in the health and rehabilitation setting and removing him from the criminal justice system may probably be the most effective method of changing his behavior. Many years of experience have proven that criminal law is not an appropriate device for preventing or controlling health problems. Dealing with public inebriates as criminals has been expensive, unproductive, burdensome, and futile. The establishment of modern public health and rehabilitation programs for the management of alcohol abuse and alcoholism facilitates early detection, prevention, and treatment of alcoholism and early diagnosis and treatment of other concurrent diseases. These programs also relieve the police, courts, correctional institutions, and other law enforcement agencies of a burden that interferes with their ability to protect citizens, apprehend law violators, and maintain safe and orderly streets.

In many cases, the police officer is the person who introduces the alcoholic person to the treatment system. For this reason, it is essential that the officer becomes well acquainted with the treatment resources in his community. Most comprehensive alcohol treatment programs have some type of central intake or receiving center that provides preliminary examinations and further refers the client to the most appropriate facility for treatment.

Numerous advantages can be gained quickly if good personal working relationships exist between the police officer and the treatment staff. Effective communication is more likely when each is familiar with the terminology and technical language of the other. Procedures can be developed to minimize the time an officer spends at the facility where and when he takes someone for treatment.

The police officer can also be extremely valuable in determining the responsiveness to supplementary services of certain individuals after they have left the treatment system. Many clients leave the treatment system and are unresponsive to any attempts to provide them with follow-up services. The officer, in many instances, has knowledge whether the person remains sober, if he is working and how he is doing on the job, and if there are pressures or situational problems present that are apt to rekindle the desire to drink. All of this represents essential information if it is communicated to the treatment staff. More important, the policeman is often able to talk to the person and influence him to seek additional treatment. Follow-up information on successful clients is also important. Sometimes, the police officer is the one most aware of those who have overcome their illness.

Law enforcement agencies and treatment resources can work together to simplify paperwork associated with alcoholism programs. Often, one simple form can be developed that will provide the police officer a record of his involvement with an inebriated person (for departmental accountability purposes) and will also give information needed by the treatment facility. Information to be contained on the form could include, among other details, such particulars as time, date, and location of incident; behavior observed; and date/time that the individual was delivered to the treatment facility. This form should be completed in duplicate—original for police record purposes and the duplicate for the treatment center files. Attached as Appendix G-1 is an example of a form currently used in Florida for the purposes just described.

The police officer must know the state law and local ordinances affecting his involvement with the public inebriate. Many states have enacted laws for the control of alcoholism. Some are very similar to the Uniform Act, while others differ in varying degrees. In many states that have decriminalized public intoxication, there are specific responsibilities that law enforcement personnel must fulfill. The officer should also be aware of pertinent department rules and procedures and, more important, exercise care in adhering to practices that insure fast and appropriate treatment.

The public inebriate is the type of problem drinker with whom the police officer most frequently comes in contact. Such individuals are often in the chronic phase of alcoholism and need immediate professional care. When a policeman contacts an inebriated

person, the officer, in a sense, represents the treatment system until the inebriate has been admitted to a treatment facility. This period of time is critical for the inebriate, the police officer, and others who are on or near the scene.

It is important for the police officer to understand the alcohol treatment system and the various components that comprise a comprehensive alcohol rehabilitation program. Just as it was important for the officer to know the separate elements of the criminal justice system and its involvement with the public inebriate prior to the Uniform Act, he must now become familiar with how the different parts of a health and rehabilitation system function to provide the services mandated by the Uniform Act.

Detoxification

Managing acute intoxication and withdrawal is a vital step in helping the alcoholic individual. He must first recover from acute intoxication and withdrawal before he can begin to change his life style. A great deal is known today about the body's reaction to alcohol, and improved medical treatment methods reduce much of the discomfort and eliminate almost all of the danger of sudden abstinence.

In acute cases, the process of "sobering up" and withdrawal should be handled in a facility where the patient can spend several days safely ridding his body of the effects of alcohol. The usual procedure is to give the patient medication that will prevent convulsions and produce a healthy appetite and sound sleep. High-strength vitamins and a diet rich in nutrients are prescribed. Encouragement and support from empathic staff members, law enforcement officers, and others with whom the patient comes into contact—some of whom may have recovered from alcoholism themselves—are essential elements in the process of seeing the patient through this part of the treatment phase, i.e., initial detoxification to complete withdrawal.

Medical treatment for other health problems is usually started during the same period in which withdrawal is being handled. Once the patient receives special care for his physical ailments, stops using alcohol, and starts eating properly, the progress of most alcohol-related illnesses can be halted. At this stage, in many cases, body organs that have been injured begin to heal themselves.

The detoxification facility is not only the treatment program entry point, but is also the component of the treatment system with which the police officer has most contact. Essentially, there are two types of facilities (medical and nonmedical)[1] that provide detoxification and emergency treatment as mandated by the Uniform Act. The medical model is normally in a hospital setting having around-the-clock medical services such as an emergency room. This mode of treatment is necessary for those patients experiencing delirium tremens or other severe complications. However, experience has shown that most intoxicated persons are able to return to sobriety in the nonmedical type facility.

[1]In the sense of "hospital" and "nonhospital" types of facilities, respectively. This differentiation is expressed primarily to point out that medical service (or supervision) is generally available to or present at a so-called "nonmedical" detoxification or emergency treatment facility.

The nonmedical facility is staffed by nurses and aides working under the direction of a physician. The physician provides standing orders and direction to the staff and is available to examine patients and make recommendations. This type of facility is significantly more economical than a hospital and meets the objectives of guarding against complications from withdrawal, restoring adequate nutrition, and providing an opportunity for prevention and/or early identification and treatment of alcoholism. Another advantage of the nonmedical facility is the supportive and therapeutic setting in which the motivational level of problem drinkers can be raised beyond that of merely "sobering up."

Hospitals

State mental hospitals have long carried the load of in-patient care for alcoholism. The National Institute on Alcohol Abuse and Alcoholism reports that the 321 state mental hospitals in the United States together have a daily census of 37,000 patients with a diagnosis of alcoholism. In about 90 percent of the state hospitals, there are no special alcoholism wards or programs, and little or no treatment for problem drinking is provided. The 10 percent that do have special programs use group psychotherapy, alcoholism lectures, discussions, movies, and Alcoholics Anonymous meetings.

In the past, general hospitals have been reluctant to accept alcoholic patients. This reluctance is disappearing gradually, and many of these hospitals are beginning to provide vital services in out-patient, emergency room, and ward care for those suffering from acute intoxication, as well as in-patient care on both the psychiatric and general wards for chronic alcoholism patients.

The general hospital is becoming a prime referral source for community alcohol treatment programs. Frequently, hospital emergency rooms provide emergency care for injuries and complications of severe intoxication and then discharge the patient to the community program. While this procedure is more economical and feasible in terms of treatment, it is often the source of frustration for the police officer. At times, he finds himself shuttling inebriates from one place to another and, in many instances, is saddled with an inebriated person that, for one reason or another, none of the treatment facilities will admit. Problems of this sort need immediate resolution or the entire community treatment program will be placed in jeopardy. Corrective procedures should receive high priority and be developed by hospital administrators, supervisors of community alcohol programs, and police authorities.

Out-Patient Care

Recent experience has shown that out-patient care is advantageous for most alcoholic patients. The reason is that the majority of alcoholic people are still trying, although with increasing difficulty, to shoulder their home, work, and social responsibilities. They are ill and in trouble, but they still have the advantage of reasonably intact life patterns upon which to build.

Out-patient services provide treatment and support in a therapeutic setting for persons whose physical and emotional status allow them to function in their usual environment, but require professional help and guidance. Services are usually offered on both a scheduled and nonscheduled basis and are coordinated with the patient's other therapeutic contacts in the community.

Because many patients enter the treatment system through the out-patient program, it is essential that an evaluation and treatment plan be developed during this phase of treatment. The patient should be interviewed, psycho-social information obtained, and a physical examination, if indicated, conducted to determine the most appropriate treatment available. Patients can then be referred as appropriate if needed services are not immediately available.

Out-patient programs have other specific goals. They normally provide group and individual therapy for patients and family members, individual and group therapy for spouses, family therapy, community education and orientation, and consultation services for other agencies in the community. Staff members of out-patient programs are sometimes assigned liaison duties with law enforcement departments, the court system, parole and probation offices, and other agencies of the criminal justice system. Out-patient facilities often provide the setting for DWI schools, Alcoholics Anonymous meetings, and other elements which comprise a comprehensive alcoholism treatment system.

Halfway House[2]

The halfway house is a most important link in the chain of the alcoholic rehabilitation services system. It can provide maximal rehabilitative opportunities for the homeless, the disabled, and the individual whose needs may include temporary supportive residential care. It is conceived to be a therapeutic service for patients who have reached "the halfway mark" toward the resumption of independent living and who simply need temporary refuge on a "dry island" or who no longer need the intensive services of a hospital or institution. It may also help prevent hospitalization for the individual who requires removal from an unhealthy home environment.

The halfway house, as the bridge between institutional and community life, emphasizes the same kind of responsibility to self and to a "home" as would be expected in a normal environment. Usually, the house is governed to a large extent by the residents who meet periodically to discuss house rules and regulations and daily living activities.

[2]The terms "halfway house" and "quarterway house" do not convey homogeneous meanings in each community where the titles may be used. There is no single definition or description that can be applied which would outline the functions carried out by facilities which are referred to as halfway or quarterway houses. Textual descriptions of these facilities are set forth in an effort to furnish the reader with a general knowledge of the function of these centers and their place in an alcoholic treatment program.

Programmatically, a halfway house provides the setting for various treatment techniques; creative recreational activities; community interaction; and spiritual, educational, and cultural activities designed to encourage social readjustment and self-development. In this setting, the residents learn to cope with the problem of life in a nondrinking atmosphere by learning and sharing with others who have similar problems.

Police officers have long been recognized for their involvement in community programs and projects. The halfway house programs are heavily dependent on volunteers and utilize their services to the greatest extent possible. Many volunteers are law enforcement officers, representatives of various philanthropic organizations, recovering alcoholic persons, members of community churches, and neighborhood residents. The talents and energies of these people contribute immeasurably to the recovery process of halfway house residents.

Quarterway House[3]

The quarterway house is a facility similar to a halfway house. The basic difference is the staffing pattern. Applying the same principle as the halfway house, the patient in the quarterway house is considered as being only a quarter-of-the-way between institutional care and independence and self-support in the community. A quarterway house requires a staff that is professionally competent in determining individual behavior which might require medical attention. The quarterway house usually has an established mechanism for securing medical care, to include hospitalization if required. Although the quarterway house resident is supervised more closely than the individual living in a halfway house, the programmatic goals are the same. That is, to enable the resident to return to a self-supporting, independent role in the community as soon as possible.

Domiciliary Care

Although representing less than 5 percent of the population of problem drinkers, there are some debilitated persons with chronic alcohol problems who are unable to receive any measureable benefits from other (than domiciliary) types of residential treatment facilities. Patients in this group have multi-faceted problems including physical deterioration and a lack of socialization abilities. Others have varying amounts of irreversible brain damage and possess no vocational skills.

Domiciliary care provides the chronically debilitated individual with shelter and care for an extended period of time. Basically, such care provides room and board and needed medicines. Some well-staffed domiciliary residences provide a systematic reevaluation process to determine the residents' potential to benefit from a more dynamic therapeutic program available in other facilities. There may be opportunities for some type of sheltered employment either at the facility or other locations in the community. Participation may also be encouraged in and arrangements made for recreational and religious activities.

[3]See preceding footnote.

Understanding the plight of the chronically debilitated skid-row person who needs domiciliary type care is most important for the police officer. Although in numbers they are few, the skid-row inhabitant is the alcoholic person most visible to society. Because of this high profile, the skid-row resident receives more than his share of attention. In fact, the circumstances surrounding his existence may be somewhat exaggerated.

First, there are not nearly enough domiciliary-type facilities to meet the need generated by the skid-row resident. Second, these individuals revolve through the other treatment facilities at such a rate that it requires a disproportionate amount of staff time and funds —time and funds which could be better expended on alcohol-related projects having a more positive potential. Third, and perhaps most important, the area comprising skid-row consumes a large portion of a policeman's time and effort. For the skid-row habitué, a treatment system without domiciliary care is highly ineffective.

Alcoholics Anonymous

One of the major resources for the treatment of alcoholism in this country has been an organization known as Alcoholics Anonymous (A.A.). It is a loosely knit voluntary fellowship of alcoholic individuals gathered together for the sole purpose of helping themselves and each other to acquire complete sobriety. It has also been pictured as first showing its members how to regain a respectable life style and then how to continue in a decent mode of living. There are almost one-half million members in about 13,000 A.A. groups in the United States.

Important to the A.A. approach is an admission by the alcoholic person of his lack of control over alcohol. He finds his life to be unmanageable and his situation intolerable. For some, this realization may come after they have lost everything and everyone. For others, it may occur when they are first arrested by the police or warned by their employer. Alcoholics Anonymous members believe that the individual must decide to turn his life and his will over to a power greater than his own. Much of the program has a spiritual, but nonsectarian, basis.

In the past, some A.A. members insisted that only an alcoholic person can understand another alcoholic person and as a result there was little cooperation between A.A. workers and others involved in alcohol treatment. Now, with comprehensive alcohol treatment programs existing throughout the country, A.A. members and the professional therapists have come to understand each other's aims. Alcoholics Anonymous is a vital component in practically all community alcohol treatment programs. Professional workers in these programs strongly encourage membership in A.A. as a part of the treatment plan for patients in detoxification centers, general and psychiatric hospitals, private clinics, and during out-patient care. It should be emphasized that, as valuable and widely accessible as it is, A.A. should not be considered as a complete form of treatment for all alcoholic individuals; rather it should be viewed as supportive to—not substitutive for—various forms of therapy.

Other organizations stimulated by the example of Alcoholics Anonymous have been most effective in involving family members and helping them to understand and adjust to the problems created by an alcoholic family member. Al-Anon, an organization of spouses and other relatives of alcoholic individuals, is available whether or not the alcoholic family member belongs to A. A. or participates in some other rehabilitation program. The value of membership in Al-Anon is the realization that one is not alone in his alcoholic predicament and has the opportunity to take advantage of the trial-and-error attempts of others toward a better adjusted life. Alateen is a parallel organization for the teenage children of an alcoholic parent.

Clergy

Clergymen are taking an increasingly active role in the treatment of alcoholic individuals. Traditionally, addictive drinking was considered to be a sin and its treatment was, therefore, thought to be a responsibility of the clergy.

The original goal of moral reform has now changed considerably. After deep reappraisal, many clergymen of various faiths have taken a new approach based on modern psychological and psychiatric knowledge. They are following the same pattern of "one-to-one" pastoral counseling procedures for people with alcohol problems as they are with those having other troubles. Clergymen are also becoming valued members of therapeutic teams in the administration of group therapy.

The clergyman and police officer, by virtue of their position in the community, can be and often are the two individuals most influential in getting those with alcohol problems into a treatment program. The minister is frequently the only person in whom those sick with alcoholism and members of their families will confide. The police officer, in his work, comes in contact with more crisis conditions, human relations incidents, and alcohol abuse situations than any other person in the community.[4]

Private Treatment Facilities

The disease concept of alcoholism is becoming widely accepted, and in addition to publicly sponsored programs there are increasing numbers of private treatment facilities emerging. The fact that alcoholism can be treated successfully, the availability of

[4]Although the police officer and the clergyman can, as indicated, be most effective, some alcoholic persons and their associates may harbor extreme negative attitudes toward either or both of these individuals. Whether such conceptions are caused by real or imagined ills is of little consequence. The primary consideration here is to be aware of these circumstances and prepare accordingly for any hostile or aggressive action on the part of alcoholic persons when suggestions concerning treatment are made to them by law enforcement officers and/or clergymen.

insurance coverage in some areas, and other types of third-party funding programs have no doubt helped to bring private practitioners into the alcohol treatment field. It should also be recognized that some individuals prefer private treatment for alcoholism and do not want to become involved in the public system.

Some of the private clinics provide a complete range of services and experience a very high rate of success. Many physicians who refused formerly to work with alcoholic patients are now engaged in treatment programs. Also, private industries are beginning to employ counselors and other alcohol rehabilitation professionals to provide needed treatment for employees.

Summary

The purpose of this chapter has been to familiarize the law enforcement official with the various functional components of a comprehensive alcoholism rehabilitation program. Just as any new type of program or change in the way things have been done for many years may result in frustration and anxiety for those involved, the placement of the public inebriate in the health care system instead of the criminal justice system will surely be no exception. To be successful, such an endeavor will necessitate cooperation and mutual understanding for everyone involved, especially law enforcement and treatment personnel.

Hopefully, both will gain greater insight into the total treatment system and not hold the mistaken thought that adoption of the Uniform Act merely decriminalizes public intoxication and moves the drunk tank from the jail to a detoxification center.

Experience has shown that in an area having an established treatment system—as opposed to one that is uncoordinated or nonexistent—the police officer spends far less time and effort with those who have alcohol-related problems. To understand the overall program and be able to influence those who need treatment to participate should be among the prime objectives of each police officer. The best treatment system in the world is useless without people to treat. The law enforcement officer can be the vital link in forging one to the other.

CHAPTER IV

IV

THE POLICE ROLE

Background

To gather data for use in this manual, and particularly this chapter; acquire first-hand knowledge of the impact that the Uniform Act brings to bear on police operations; and to experience related environmental conditions, a series of visits by highly qualified law enforcement practitioners were conducted during 1975 to a number of selected sites. All of the places visited were located in states which had enacted the Uniform Act or similar legislation. Observations were made and interviews were conducted at the state, county, and municipal-urban levels.

Purpose

It is the purpose of the first section of this chapter to set forth in general terms certain of the impressions gained and conditions noted during the course of the visits just described. The remainder of the chapter is devoted to the examination of certain provisions in the Act in an effort to provide guidance to the individual officer in situations likely to be encountered as a result of the Act's establishment.

Supplemented by classroom or roll-call training, assimilation of the information presented in this portion of the manual will serve to prevent some of the situations about to be described.

Section 1 - Implementation Inconsistencies at Various Jurisdictional Levels

General

Although a number of positive aspects were noted concerning the Act's implementation in the jurisdictions visited, primary consideration is given below to the more negative situations which were encountered. Using this approach, emphasis can be placed on certain of the more common errors/misconceptions which are committed/held by those

charged with executing the Act's provisions. Based on this knowledge, responsible authorities can direct their operations and training commitments in a more positive and constructive fashion in an effort to remedy or prevent improper actions—actions which sometimes result from attempts to circumvent the spirit or letter of the Act.

State

Observations and analyses of state enforcement agencies with respect to their operations and policies regarding public inebriates disclosed the following:

Nature of the Work. State-level enforcement operations are largely committed to the patrol of state and federal highways and are chiefly concerned with violations of the traffic code. Relatively little contact is made with intoxicated persons in the sense of the Uniform Act. State-level enforcement rarely involves officers responding to calls concerning inebriated persons in drinking establishments, domestic disturbances, or other similar situations. These are largely the routine types of calls encountered in some areas of urban operations and seldom involve state officers.

Driving While Intoxicated/Accidents. At the state level, contact with people under the influence of alcohol is generally connected with some driving offense or accident investigation. In the former situation, custody of the offender usually takes the form of incarceration in the nearest jail. In the latter situation, the need for medical treatment of injuries generally requires transportation of the offender to a hospital. Later, prosecution will ensue through complaint, arrest, or summons.

Refer to Local Agency. In contacts with intoxicated persons where no traffic offense is involved, local police are generally summoned by state officers to "take care of the matter." Some exceptions occur when passengers of vehicles involved in accidents are inebriated and need to be "handled." In this case, a friend may be called to the scene, a taxi may be requested, or the officer may elect to help in some other way. Occasionally, even a tow-truck operator may be enlisted to help transport the individual to a place where assistance may be secured.

Jurisdictional Policy. Although most state-level enforcement agencies have jurisdiction throughout the state, and thus, concurrent jurisdiction in any local area of government within that state, patrol and enforcement efforts are largely confined to those areas not covered by the respective local agencies. Exceptions exist, but even these are often the result of some previous agreement or understanding between the agencies involved.

Specialized/Limited Jurisdiction. Some state enforcement officers have specialized or limited jurisdiction in or around the state capitol buildings and grounds and/or other state buildings and properties. For the most part, inebriates are encountered sleeping or loitering in and about public buildings and adjacent areas. Since these facilities, or limited jurisdictions, are usually in the heart of a major

city, the state officers concerned generally take appropriate action similar to that practiced by the local police agency. A routine is usually established for picking up public inebriates and taking them directly to a treatment or locally-termed "detoxification" center or to the appropriate custodial facility for temporary confinement.

Rural Coverage. State-level law enforcement agencies usually operate in jurisdictions that are predominately rural and located some distance from urban centers. This means that even in those cases when a state officer may encounter a public inebriate and decide to transport that person to a treatment center, rarely will the facility be close at hand. Frequently, such a decision may involve a trip of considerable distance, thus reducing or actually eliminating police coverage in the area concerned for a period of hours of more. As a result, police are reluctant to take such action. Moreover, the often-experienced futility of trying to arrange transportation for an inebriate to a treatment facility may influence the officer to ignore or avoid the situation.

Training. Training for state police officers is generally very extensive. Subjects connected with alcoholism, however, usually revolve about the situation of the drunken driver. Little or none of the curricula covers the public inebriate. Likewise, little or no documentation exists in state officer training material regarding the public inebriate or the total alcohol treatment program, with the exception of a few "roll-call" type training bulletins in some agencies.

Vacation/Resort Area. Vacation or resort areas, when not under the jurisdiction of a local agency, sometimes pose a problem for state officers. Here, apart from the expected congestion and attendant traffic problems, instances of public drunkenness also increase sharply. Approved public treatment facilities or emergency medical services are generally not positioned to service a seasonal situation. The state officer who is required to deal with the matter of public intoxication under these circumstances must seek alternate measures to cope with the situation. As a result, misunderstanding and disinterest in the treatment program are fostered.

Advisory Group. In few instances at state enforcement levels are close coordination and cooperation maintained between the police and officials who are responsible for alcoholism treatment programs or those officials who operate treatment facilities. If liaison has been established, or if an advisory group exists, police representation is generally evidenced by someone from the police agency of the closest major city. This may tend to isolate state-level officers from input or receipt of information that could affect overall enforcement coordination in dealing with public inebriates. Indeed, in one instance observed during the data-collection phase for this manual, the health official responsible for a particular state's treatment program had made no attempt either to contact or coordinate with the appropriate state police authorities.

Location of Centers. Often, many officers know neither the location of emergency treatment centers nor the services that are available. Even though lists of these facilities may be published, distribution does not always reach the lower echelons of law enforcement agencies. One serious ramification of this shortcoming is the fact that in

states where the Uniform Act has been enacted intoxicated persons are sometimes confined in detention cells illegally, opening the agency concerned to a possible law suit.

County

Enforcement operations at the county level in connection with public inebriates have the following shortcomings:

Suburban Jurisdiction. Similar to state-level enforcement operations, county officers generally confine their activities to suburban and rural areas and perform traffic road patrol on county and state highways. This type of operation does not generally result in contact with the public inebriate.

Custodial Operations. County-level enforcement operations frequently involve the administration and operation of a county jail facility. Where city agencies are phasing out their custodial functions, the county jail becomes the locus for all bookings in that county. Wherever permissible under statutory provisions, public inebriates are often held in these county jails in lieu of admission to treatment centers.

Distance from Treatment Center. The rural and often-decentralized operations of county enforcement agencies sometimes present a problem for the county officer when he encounters a public inebriate who should be transported to a treatment facility. The chief item at issue is generally the distance that must be traveled to bring the subject to the place of treatment. Since most facilities are situated in the

center of urban areas more likely to be frequented by the public inebriate, they are not conveniently located for use by officers in rural and suburban areas. Rather than resort to traveling a long and time-consuming distance to a treatment center, county officers frequently elect other options, i.e., avoidance of the problem or incarceration of the intoxicated person in the nearest jail. Here, a situation similar to that encountered by the state-level officer is manifested. To combat this problem, however, some areas are making efforts to establish "auxiliary" treatment centers to serve the rural population.

Training. Since the frequency of contact with intoxicated persons, and thus familiarity with the alcohol treatment program, is quite low, county officers' training in this area is either nonexistent or very limited. Although extensive training material may be present for handling drunken driving offenses, little reference to the public inebriate is found in the training program. Moreover, where county jails are used for centralized bookings by an urban agency, a lack of documented policy and procedure is usually evident concerning the manner in which the treatment facility should interface with county law enforcement operations.

Nature of the Work. Similar to the outlook held by state-level officers, county police and sheriffs' officers generally view the problem of public intoxication as falling within the purview of municipal police in the central urban areas. Apart from centralized jail functions, county-level officers rarely see the need to direct any great degree of their activity, training, or administration toward the subjects of public intoxication and the alcohol treatment program. In fact, due partly to a misunderstanding of what is being attempted through the decriminalization program, open hostility is often voiced by county law enforcement officials when subjects relating to the Act are broached.

Advisory Group Coordination. Again, similar to the situation found at the state level of police operations, county officers are rarely found as members of advisory or coordinating groups along with officials who administer and operate alcoholism programs and treatment centers.

Program Effectiveness. Since, to some extent, the volume of inebriates booked at a centralized jail facility can be used as an indicator in evaluating the success of a treatment program, county officers are often puzzled that these bookings sometimes appear to continue at approximately the same rate as that experienced prior to the establishment of a nearby detoxification facility. In seeking some explanation for this phenomenon, it was determined that admissions to the detoxification center do not wholly involve referrals by police, but also reflect walk-ins, admissions from other agencies, and readmissions of former patients. However, viewed from the county officer's point of view, the detoxification program seems not to have relieved county jail operations of any significant number of bookings for public intoxication.[1] Ergo,

[1]Again, attention is directed to the fact that in states which have enacted the Uniform Act the incarceration of persons solely because of their consumption of alcoholic beverages is unlawful.

the program is not operating effectively and has only succeeded in creating another welfare agency. This misconception is frequently buttressed by the lack of the exchange of information and coordination between alcoholism program officials and county-level enforcement officials.

Planning. In some instances when alcohol treatment programs are launched, little prior planning and coordination are initiated or maintained with county officers. These shortcomings exist even though centralized booking procedures operated by county officers represent important links in the overall scope of alcoholism programs. This lack of prior planning, coupled with the anticipation that bookings would decrease, causes a considerable amount of confusion, distrust, and misunderstanding concerning the program's objectives.

Admission Procedures. In some county-level operations, field officers find that it is easier to book an intoxicated person at the jail instead of waiting at the detoxification center for the individual to be screened for admission. Although the officers must report a "justification" for such action to their agency, this requirement is circumvented by indicating the charge as: "fighting," "violent," "too intoxicated," or "refused." On the other hand, this practice may simply be reflective of actions observed at detoxification centers where admittance of an alcoholic person is often denied for similar reasons.

Municipal-Urban

The following observations were noted in connection with municipal-urban (local) operations pertaining to the handling of public inebriates, alcoholism treatment programs, and public treatment facilities:

Information. Although some documentation is prepared and distributed to field personnel to make them aware of the changes brought about by the adoption of the Uniform Act, it is most often a one-time effort and not generally supported by sufficient review, follow-up, and retraining.

Operational Expediency. Field personnel, who normally patrol "skid-row" areas, generally exhibit a practical attitude when dealing with drunks and the treatment facility center. This often manifests itself through the medium of certain "expedient" measures, which become routine with practice. These measures may take the form of transporting an inebriate to a mission-operated shelter or "flop house" and depositing him there to fend for himself, or he may be deposited at the treatment center to seek admission on his own behalf as a "walk-in." Whatever the case, the requirement to bring the person to the district station jail and complete a protective custody or arrest report has been avoided.

Treatment Center Capacity. Field officers are frequently confronted with the problem of being unable to find room at treatment centers to accommodate all of the

public inebriates in need of assistance. This situation produces a lack of interest in the program or a feeling of frustration on the part of the police officer that nothing has changed, i.e., police still must pick up inebriates and take them to jail only to see the same individuals released after a few hours of "sobering up."

Involvement. Numerous officers are of the opinion that they were to be relieved of the task of handling the public inebriate once the Uniform Act was adopted. Unfortunately, through a lack of complete understanding of the program, poor coordination with program officials, or simply disinterest and frustration, many officers fail to see any short- or long-term benefits emanating from the Act's passage.

Advisory Group Representation. Coordinative or advisory groups that function in connection with alcohol treatment programs frequently have interface with the local police. This is usually accomplished through representation in the group by a high official or administrative officer of the police agency. As a general rule, however, officers from the operational levels, especially in those areas of the city in which the majority of public inebriate contacts are made, are not contacted or permitted to interact with these groups. As a result, decisions are often made that simply do not reflect the practicality of the situation, but exist as blue-sky idealistic theories which further compound the inability of the officer to view the overall program in a positive light.

Training. Provisions are generally made during police recruit training courses to have officials of state and local alcoholism programs present an overview lecture regarding the treatment program to each class. Documentation in this area, however, is sparse and limited to brief explanations of the specific statute involved and/or procedural matters. Little background material is available on the many ramifications of alcoholism as a disease and social problem.

Program Funding. Officials of various alcohol treatment programs as well as police administrators are virtually unanimous in their desire to see that future efforts to provide treatment to alcoholic persons are adequately funded prior to the inception of any specific program. In more than one state, the Uniform Act was passed by the legislature but no funds were appropriated for implementation. The result was to provide a complexity of problems and frustrations that has required years of additional effort to be devoted toward the resolution of this error.

Program Planning. In addition to inadequate funding, the lack of proper planning is often voiced as an equal concern. Sites for treatment facilities must be selected on a basis of proximity to the problem area and in consideration of the logistics involved. Similarly, the capacity of the center or centers must be able to support a reasonable input potentiality sufficient to deal with the activity likely to be encountered. A 20-bed facility in an area that has a daily requirement for 100 beds will not be able to achieve any measure of success despite the contention that "it is a step in the right direction" or "it is better than nothing."

Collection Teams. The use of treatment center personnel who function as "rescue squads or teams"[2] equipped with their own vehicles to pick up public inebriates is viewed by police as a desirable adjunct to any alcohol treatment program. This opinion is held universally despite the fact that it does not entirely relieve the police of the need to supplement this service by assisting in the pick-up and transportation of public inebriates to a detoxification facility.

Urban Renewal. A fact not readily apparent concerns the impact of urban renewal programs on the general life style of the public inebriate in a metropolitan environment. As various portions of a city's core are razed to make space available for the planned development of more practical and pleasing surroundings, an untoward (with respect to the intoxicated or incapacitated person) circumstance evolves.

The resultant problem stems from the almost total disappearance of the public inebriate's environment. Before renewal operations were commenced, the derelict or occupant of the area knew where he could sleep on a cold night (be it a doorway or a warm-air ventilation shaft), where he could cadge a meal, where he could find a "flop" for a small sum, and, if necessary, which jail would accept him as a "lodger."

With the advent of urban renewal, all of this changed. The world of the public inebriate collapsed—he was thrown into a more unfriendly, barren community than the one with which he had become so familiar. To compound his troubles, he knew nothing of the "decriminalization of public drunkenness," and he didn't know that hospitals were supposed to treat him (anyway, he probably would never enter voluntarily a spic-and-span, chrome-plated emergency ward)—even the police would no longer charge him with being "drunk in public" so that he could spend a period of recuperation as a guest of the city.

Result: His existence became more miserable since now the police often overlooked his plight and/or approved public treatment facilities were either full or refused him admission. All of this, combined with the lack of his previous means of acquiring a livelihood, further worsened his already deplorable condition.

Common Inconsistencies

In addition to the aforementioned observations and comments, the following remarks are set forth as being applicable in some degree at all enforcement levels:

Modification of Act. Numerous law enforcement officials are in favor of an amendment to the Act as implemented by their respective states. They believe that a

[2]In the Uniform Act, these teams are referred to as "emergency service patrols."

provision (similar to the Massachusetts law) should be inserted allowing for a 12-hour "drying out" period (protective custody) in a detention facility. Those supporting this change contend that such a provision would allow law enforcement agencies greater flexibility and influence in carrying out the intent of any legislation pertaining to the decriminalization of public drunkenness. These authorities also contend that allowing short periods of incarceration for public inebriates would act as a pressure valve by providing an outlet or secondary "drying out" facility when other institutions have reached their capacity.

Hospital Cooperation. Police officials spoke of the lack of cooperation of state medical personnel when, for various reasons and excuses, they refuse to admit public inebriates for purposes of treatment, i.e., lateness of the hour or when the detoxification center (emergency ward) has reached its capacity. The question posed by the police is: Can a public (or private, for that matter) hospital legally refuse to admit a public inebriate, under provisions of federal law, when that hospital is receiving any federal monies? Unequivocally the answer is: No, they cannot refuse treatment.

Involuntary Commitment Policy. Many law enforcement authorities expressed concern over the lack of "involuntary treatment" provisions in their respective state statutes. Most felt that when the nature of a given individual's problem with alcohol began to follow a predictable pattern (for instance, the "revolving door" syndrome) then that individual should be legally required to submit to a program of involuntary treatment.

Funding. One adverse aspect of receiving and using federal or other initial funds to support the provisions of the Uniform Act as implemented by the various states concerns the durability of agencies or programs sustained or initiated by or because of these funds. Once established and accepted, projects funded in this manner become an integral part of a particular program and soon acquire an aura of permanency. Unfortunately, once the initial funding base is removed, the program is often dropped (since the community concerned cannot afford its continuance) and a once useful service is discontinued.

The situation just described points up the importance of community participation and involvement during the planning for grant aid. During this phase, the possibility and extent of local funding should be explored.

Reporting. In some instances, after a police officer has delivered an inebriate to an emergency treatment or detoxification center, it is necessary for the officer to execute long and involved forms describing the incident and justifying his actions. It is readily apparent that this is an onerous task and the necessity for its accomplishment may militate against an officer's desire to engage in future transport operations.

Observations indicate that records-keeping procedures at both police headquarters and treatment centers for alcohol abuse are in need of review and revision. If the police are to perform a collection service or make referrals, the transaction should be a relatively simple process characterized by a minimal amount of time spent in the

preparation of forms. Officers generally voice complaints regarding "paperwork" and normally gravitate toward the path of maximum practicality and least effort. The same principle holds true in a hospital or detoxification center where an officer may be required to wait and furnish lengthy details for an admittance report.

Section 2 - The Uniform Alcoholism and Intoxication Treatment Act and the Law Enforcement Officer

Background

Primarily because of the recommendations forwarded in 1967 by the Task Force on Drunkenness of the President's Commission on Law Enforcement and Administration of Justice[3] and the 1966 Report of the President's Commission on Crime in the District of Columbia,[4] the National Conference of Commissioners on Uniform State Laws in 1971 drew up and approved what is known as the Uniform Alcoholism and Intoxication Treatment Act.[5] Both of these Presidential commissions concluded that drunkenness, of itself, should not be classed as a criminal offense. The members of these commissions also determined that dealing with alcoholism and the public inebriate by resorting to court action was not only inhumane and futile, but expensive as well. It was also considered to be counterproductive since no evidence was produced that recourse to legal procedure had ever corrected the problem. As a result, both bodies stated that instead of initiating criminal proceedings against the common drunk, a more positive step would be to enlist the services of public health authorities and their facilities. In other words, drunkenness and alcoholism should be looked upon as an illness and public health problem—not as a crime.

Highlights of the Uniform Act

After declaring the state policy pertaining to alcoholics and intoxicated persons, the Act defines relevant terms and outlines the organization, powers, and duties of the state division of alcoholism. Following this, the establishment of an interdepartmental coordinating committee[6] is outlined and the appointment of a citizens advisory council on alcoholism is described.

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[3]See pp. v, vi, "Foreword"

[4]See Appendix H, "Summary of Recommendations," Report of the President's Commission on Crime in the District of Columbia (Washington, D.C.: U.S. Government Printing Office, 1966), pp. 502, 503.

[5]See Appendix B, Uniform Alcoholism and Intoxication Treatment Act, 1971.

[6]To be comprised of the director of the state division of alcoholism and the commissioners of public health, mental health, education, public welfare, correction, highway, public safety (emphasis added), vocational rehabilitation, and other appropriate agencies.

Next, the Act requires that the state division of alcoholism establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. In this respect, the program should be designed to include:

- Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital[7] (emphasis added)
- In-patient treatment
- Intermediate treatment
- Out-patient and follow-up treatment

Therapy may be requested or received by an individual at public or private treatment facilities under various circumstances. If at all possible, however, the Act maintains that a patient should be treated on a voluntary, not involuntary, basis.

Primarily, three types of problem drinkers are addressed by the provisions of the Uniform Act. The Act categorizes the individuals as the:

- Alcoholic
- Intoxicated person
- Incapacitated person

It is most probable that law enforcement officers will experience the greatest frequency of contact with the latter two categories (who may or may not be alcoholics)—and within these categories the most contact (85 percent to 90 percent) will be made with the intoxicated person.

Specifically, with regard to treatment,

- An alcoholic person may apply voluntarily directly to an approved public treatment facility. Even if the individual is an incompetent

[7] This facility is often referred to as a "detoxification center."

person or a minor, application for admission may still be made by the proposed patient, or by a parent, a legal guardian, or other legal representative;

- An intoxicated person may also come voluntarily to an approved public treatment facility or, provided he agrees to be helped, may be assisted by the police or emergency service patrol personnel to his home, an approved public treatment facility, an approved private treatment facility, or other health facility; however,

- An incapacitated person must be brought by the police or emergency service patrol personnel to an approved public treatment facility for emergency care.

For the purposes of providing emergency treatment, the Uniform Act stipulates that a public treatment facility may admit and detain the following types of patients for a maximum of five days:

- An intoxicated person who has threatened, attempted, or inflicted physical harm on another

- A person incapacitated by alcohol

Although employing the authorized sanction of administering a short-term period of commitment in emergency situations may arise only infrequently, this proviso has been inserted in the Act to afford a means of handling situations not addressed elsewhere in the model law.

Upon petition of an alcoholic person's spouse or guardian, a relative, a certifying physician, or the person in charge of an approved public treatment facility, and following the issuance of a court order, the Act makes further provision for the involuntary commitment of an alcoholic person for a maximum of 30 days,[8] when the petition alleges that the person concerned:

- Is an alcoholic who habitually lacks self-control concerning the use of alcoholic beverages; and

[8]Under certain conditions, the patient may be recommitted for a period not to exceed 180 days.

- Has threatened, attempted, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or

- Is incapacitated by alcohol.

The confidentiality of a patient's records maintained by treatment facilities is protected by a provision in the Uniform Act. Likewise, a patient's mail or other communications may not be intercepted, read, or censored. The Act also specifies that the patient be granted time for consultation with counsel, and contact with family and friends as appropriate.

The Act further authorizes a state division of alcoholism, county, city, or other municipality to establish emergency service patrols. It is the responsibility of the state director of the division of alcoholism to devise rules and procedures for the establishment, training, and conduct of emergency service patrols.

Section 3 - Provisions of the Uniform Act of Particular Interest to the Law Enforcement Officer

Decriminalization of Drunkenness as an Offense

Undoubtedly, in the eyes of the police officer, the most far-reaching assertion in the Uniform Act is contained in the section which states that "...alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages (emphasis supplied) but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society."[9] In short, once the Act is adopted, in the jurisdiction affected a person may no longer be arrested merely for being under the influence of alcohol. Hence, many petty criminal offenses such as loitering and vagrancy will, in turn, be disassociated from being handled in connection with drunkenness. Likewise, a person under the influence of alcohol who may evidence this condition by staggering or lying unconscious in a hallway will no longer be subject to criminal proceedings, but must be handled as provided for in the Uniform Act.

[9]Section 1. (Declaration of Policy.), Uniform Alcoholism and Intoxication Treatment Act, 1971.

Coping with the Inebriate: Police Actions

At First Sight: Determination of Subject's Condition. On contacting or observing an individual who displays the general characteristics normally associated with drunkenness, a police officer must immediately attempt to determine the person's true condition. This evaluation process is extremely important as the officer's resultant decision will dictate the type of action to be taken. At this point, a number of judgmental alternatives are available to the police officer; for instance, he must decide whether the person concerned is:

- Intoxicated;
- Incapacitated;
- Neither intoxicated nor incapacitated, but has been drinking;
- Mentally ill;
- The victim of an accident;
- Under the influence of narcotics or drugs; or
- Subject to an illness or physical disturbance in which the external symptoms are similar to those exhibited by an individual under the influence of alcohol.

With respect to the alternatives just listed, a law enforcement officer's actions under the model law are limited to dealing with persons falling within the first two categories, i.e., intoxicated or incapacitated. If the person being observed, although he has been drinking, is neither intoxicated nor incapacitated, then the police officer should not interfere—unless there is reasonable cause to suspect the occurrence of an accident or foul play or if the commission of a criminal act has been observed. The remaining categories in the listing should be handled according to approved police agency policy and procedure as outlined in applicable directives.

Regarding the two types of inebriates (intoxicated person and incapacitated person) covered by the Uniform Act, unless changed by state statute, a law enforcement officer may take certain steps in the case of an intoxicated person, but the officer is required to initiate action if he encounters an incapacitated person. Because of the frequent reference in the Uniform Act to and the fact that many of the Act's provisions are built around both the intoxicated person and the incapacitated person, it is incumbent upon the police officer to become highly conversant with the identifying features of both types of inebriates.

ALCOHOLIC
EPILEPTIC
CARDIAC
PATIENT
HIGH
BLOOD
PRESSURE

If an officer or his supervisor is satisfied with anything less than a complete understanding of the Act's intent as it pertains to the handling of persons under the influence of alcohol, then the Act itself will be of little consequence in its attempt to accomplish its objective—that of affording treatment to those involved with alcohol so that they may become productive members of society. The law enforcement officer represents the first link in the chain leading to an alcoholic's realization of a useful life. Without this link, the chain cannot be forged.

Whether or not an individual is either intoxicated or incapacitated is largely relative. "Intoxication" implies that the mental and motor senses have been "substantially impaired" because of alcohol. Here, "substantially" is defined as "to a large degree."

It follows, therefore, according to this definition, that an intoxicated person should manifest a large degree of impairment in his mental and physical functions such as calculating, writing, reasoning, speaking, walking, and seeing. However, if after consuming a quantity of alcohol a person exhibits a relatively lesser degree of sense-deterioration, then that individual cannot be considered as being intoxicated. It must be borne in mind that, under the terms of the Act, a substantial or high degree of impairment must be present before an individual may begin the processing sequence as an intoxicated person.

"Incapacitation," on the other hand, describes the condition of a person who because of the consumption of alcohol "is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment." It is fully recognized that unless an incapacitated person is unconscious due to his use of alcohol, applying the definition of "incapacitated by alcohol" presents some difficulty and requires a police officer to exercise sound judgment. The following

comments are designed to assist the law enforcement officer in determining whether a person falls within the Act's definition of "incapacitated by alcohol."

Applying the test of relativity in an effort to evaluate an individual's condition which has resulted from the consumption of alcohol is perhaps the best method of determining whether that person is incapacitated. It is axiomatic that all persons incapacitated from alcohol are also intoxicated persons. However, whereas an intoxicated person evidences substantial mental or physical impairment, to be considered as incapacitated, an individual must manifest a more than substantial impairment of his senses. In other words, the incapacitated person must, in the eyes of the evaluator, exhibit a greater or larger degree of impairment than a person who, according to the same evaluative criteria, would be judged as intoxicated. Also, statistics have borne out the fact that only a small minority of intoxicated persons are found to be "incapacitated" in the sense that the term is used in the Act.

It should be noted that the Uniform Act's definition of "incapacitated by alcohol" addresses only two conditional elements, i.e., unconsciousness or impairment of judgment. Although unconsciousness, extreme incoherency, and a dazed or stupefied demeanor are easily and quickly ascertained, determination of the second element, "impairment of judgment," is largely a mental condition and is not readily discernable. Because of this latter circumstance, the police officer must examine the person concerned in more detail. To do so, the officer should request the subject to undergo a simple test such as one which would permit observation of the subject's balance or coordination. However, should the subject of the proffered test refuse to submit to such an examination—which he may lawfully do—then the officer must resort to his own best judgment and proceed accordingly.

The Act, itself, recognizes that there is no absolute method by which a person may be judged as being either intoxicated or incapacitated. This fact is borne out in the language of the Act by employing the indeterminate phrases "...appears to be intoxicated..." and "...appears to be incapacitated..." (emphasis supplied). By not using the positive phrases "...is intoxicated..." and "...is incapacitated...", the Act takes note of the dilemma which may face the law enforcement officer as he attempts to determine to what degree an individual has been affected by the consumption of alcohol. In other words, the wording of the Act does not state that the officer must be correct in his determination of a person's condition (intoxicated or incapacitated); it implies, however, that the officer is expected to exercise his best judgment.

After Determining an Inebriate's Condition. After a determination of an inebriate's condition (intoxicated or incapacitated) has been made, the law enforcement officer is committed to a series of continuing actions which are governed by the condition assigned to the subject by the officer. This section will discuss how these actions or duties should be accomplished.

Prior to setting forth these duties, however, two important considerations concerning the Act should be mentioned:

- The provisions of the Act do not differentiate between juvenile or adult inebriants. Therefore, the actions that a law enforcement officer takes in the case of an adult may, under similar circumstances, be taken with a juvenile.

- The provisions of the Act, in the form that receives state legislative approval for enactment, may differ from state to state. Accordingly, individual state statutes should be reviewed by persons concerned to determine whether variations exist between the model law and their respective state acts. Discussion of the Act as set forth below will relate to its provisions as they appear in Appendix B, without variation or change. Necessarily, of course, state law applicable in the jurisdictional area of concern will in all cases take precedence over provisions of the model act (Appendix B).

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Actions which may be taken with respect to an intoxicated person may be initiated only if that person appears to be in need of help.

Once the law enforcement officer or emergency service patrol member[10] determines that a person is intoxicated and in need of assistance, the inebriate may, provided he consents, be helped to:

- His home,[11]
- An approved public treatment facility,
- An approved private treatment facility, or
- Another health facility; or, if permitted by state statute,
- Placed in protective custody in a detention facility.

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[10]It is suggested that only the police, ambulance personnel, or the emergency service patrol transport intoxicated or incapacitated persons to their home, a treatment center, or an emergency medical service facility, as the case may be. This statement is based on the wording of Section 17 of the Act which indicates that members of the emergency service patrol are trained to give assistance to public inebriates and provide first aid in emergencies. Allowing only the personnel mentioned to transport inebriates will help to avoid possible liability (should a police officer request or designate a private citizen or other person to transport a drunken person) for any injuries that intoxicated or incapacitated persons might sustain during the time they are being transported.

[11]To include habitat, house, domicile, such as motel, hotel, boarding house, or tourist home—especially when the inebriate, who may be a stranger in the area, does not wish to be admitted to a treatment or health facility.

It should be borne in mind that an officer must not attempt to transport or otherwise assist an intoxicated person if that person does not agree to accompany or receive help from the officer. Provided the individual concerned is conducting himself in a lawful manner, and is intoxicated—but not incapacitated—then, under the Act, that person has the right to refuse to be taken to any of the places listed in the foregoing paragraph. When the conditions just mentioned are met, noncompliance with an officer's offer of assistance is perfectly legitimate and the person concerned should thereupon be left to his own devices.

It should be noted, however, that an inebriate who is seen unmistakably as causing or about to cause harm or injury to himself or others probably has his judgment so impaired that he should be considered as being incapacitated instead of merely intoxicated. In this instance, subsequent actions taken by a police officer or emergency service patrol member should follow the guidelines set forth in the next section.

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If a law enforcement officer decides that an individual is incapacitated due to alcohol, the officer must place that individual in protective custody[12] and forthwith bring him to an approved public treatment facility. In this instance, there is no requirement for an officer to gain the approval or consent of an incapacitated person before bringing that person to an approved public treatment facility. In short, the officer must assist an incapacitated person to a public treatment facility, and the incapacitated person must accompany the officer to that facility.[13]

While transporting an incapacitated person to a treatment facility, the officer should make every reasonable effort to protect the incapacitated person's health and safety. Of course, the officer should also take all reasonable measures to protect himself. This includes the use of handcuffs or other authorized restraining devices if the detaining officer considers such action to be necessary.

The primary purpose of a police officer's involvement with an incapacitated person is to protect and deliver that person to an authorized facility that has the capability to administer treatment. Although reasonable force may be employed when a recalcitrant incapacitated person is encountered, it is unconscionable to allow or cause an otherwise avoidable injury to be received by an individual who is already beginning (has been placed in protective custody) the process of being treated for another illness.

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[12]No arrest or other record may be made to indicate that the person concerned has been arrested or charged with a crime. (See definition of "protective custody," Appendix A.)

[13]If an officer is called to a private dwelling, he may take the same action with respect to the incapacitated person as would be taken in a public place, i.e., the incapacitated person must be assisted, involuntarily or voluntarily, to an approved public treatment facility.

After an incapacitated person is taken into protective custody, the Uniform Act prescribes that he be brought "...forthwith..." (emphasis supplied) to an approved public treatment facility for emergency treatment. The meaning of "forthwith" is "immediately" and is used to emphasize the promptness with which the incapacitated person must be taken to a place of treatment. To underscore further the necessity for immediate transportation to a treatment center, the Act makes provision for the use of an alternate site if an approved public treatment facility is not readily available.[14, 15]

Aside from the relative unavailability of transportation, the police officer may be confronted with another obstacle in his attempt to bring forthwith an incapacitated person to an approved public treatment facility. In this case, the obstacle is presented in the form of an overcrowded treatment facility which has no available space for the accommodation of the inebriate. It is possible, too, that this obstacle may become evident when hospital (emergency medical service) personnel contrive to prevent the admission of or arbitrarily refuse admission to an incapacitated person[16] who has been brought to the facility by a police officer.

In the former instance (overcrowded conditions), the Act makes provision for transportion of the incapacitated person to a substitute site.[17] If the substitute site has also reached its capacity, then the next most available emergency treatment center should be contacted. This procedure should be repeated until it is no longer logical to continue. Failing in a concentrated attempt to secure admission for the incapacitated person at an approved facility, the detaining officer should make every reasonable effort to find a location where it is probable that the individual concerned will be afforded the best possible treatment under the circumstances, i.e., a recognized clinic, the individual's home, or a physician's office.

In the case of an emergency medical service facility or hospital refusing admission to an incapacitated person for no apparent reason or on grounds other than those just discussed,[18] a law enforcement officer can do little except refer the matter to the state division of alcohol, either directly or through local channels. However, although after-the-fact and not of immediate assistance to either the police officer or incapacitated person concerned, once such information or complaint reaches the federal level

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[14]Here, the Act says, "If no approved public treatment facility is readily available, he (the incapacitated person) shall be taken to an emergency medical service customarily used for incapacitated persons."

[15]With regard to the ready availability of transportation and because of the transportation requirements levied by the Act, police officials should emphasize the need to appropriate governmental authorities for the establishment of an adequate number of emergency service patrols (rescue squads) in the jurisdiction concerned.

[16]In the sense of Public Law 93-282, both constitute illegal acts.

[17]See footnote 14.

[18]Except that after undergoing a medical examination the person concerned is found not to be incapacitated and is not admitted for that reason. In this instance, the person may be referred to another treatment facility, or if he has no funds he may be taken to his home. In any event, it is incumbent upon treatment facility personnel to assist the individual in finding shelter.

and is found to be valid, there are certain sanctions that may be levied against the hospital in question.

In this respect, Section 121.(a) of Public Law 93-282[19] amends Section 321 of Public Law 91-616,[20] in part, as follows:

> Sec. 321.(a) Alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse or alcoholism, by any private or public general hospital which receives support in any form from any program supported in whole or in part by funds appropriated to any Federal department or agency.
>
> (b)(1) The Secretary is authorized to make regulations for the enforcement of the policy of subsection (a) with respect to the admission and treatment of alcohol abusers and alcoholics in hospitals which receive support of any kind from any program administered by the Secretary. Such regulations shall include procedures for determining (after opportunity for a hearing if requested) if a violation of subsection (a) has occurred, notification of failure to comply with such subsection, and opportunity for a violator to comply with such subsection. If the Secretary determines that a hospital subject to such regulations has violated subsection (a) and such violation continues after an opportunity has been afforded for compliance, the Secretary may suspend or revoke, after opportunity for a hearing, all or part of any support of any kind received by such hospital from any program administered by the Secretary. The Secretary may consult with the officials responsible for the administration of any other Federal program from which such hospital receives support of any kind, with respect to the suspension or revocation of such other Federal support for such hospital. (emphasis supplied)

Although a situation brought about by the arbitrary decision of hospital personnel to deny admission to alcohol abusers or alcoholic persons suffering from medical conditions is disconcerting and frustrating to law enforcement personnel, it points up a situation in the community that requires attention and rectification. The chief of police or other appropriate law enforcement official should, on his own initiative, take immediate steps to ameliorate the conditions responsible for the actions of the personnel involved. Every effort should be made to insure that emergency medical service personnel understand the provisions of the Act, Public Law 91-616, and Public Law 93-282, as well as the reason for bringing public inebriates to a hospital.

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[19] Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974. Public Law 93-282 (Appendix D).

[20] Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Public Law 91-616 (Appendix C).

Measures should be introduced in the community designed to nurture a spirit of cooperation between medical personnel and the police. Recourse to legal sanctions, although proper, sometimes fosters misunderstandings and generates feelings detrimental to harmonious relations. For these reasons, it is far better to arrive at a solution devised by the principals rather than receive direction from an outside agency.

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In general, the law enforcement officer is considered to have fulfilled his obligation as outlined in the Uniform Act after he has assisted an intoxicated or incapacitated person to an approved public treatment facility, emergency medical service, or other specified destination. Of course, if an individual being escorted becomes intractable once he has been admitted for treatment, the escorting law enforcement officer should lend that assistance necessary to preserve order.

Searching Intoxicated or Incapacitated Persons. With respect to search and seizure, the Fourth Amendment to the Constitution reads in part, "...the right of the people to be secure in their person, houses, papers, and effects against unreasonable searches and seizures shall not be violated." In other words, this Amendment protects all citizens against searches and seizures having no legal basis or which are not carried out according to law.

Also, before conducting a search of the person of an individual who is intoxicated or incapacitated, the police officer must understand the following terms:

- Frisk. A cursory search of a suspicious person for weapons large enough to be detected through clothing.

- Field Search. A more detailed search of an arrested person in which every square inch is covered and both weapons and evidence are removed. In the field search, the officer may go inside the prisoner's clothing to remove objects which might be used as a weapon or which might have evidentiary value.

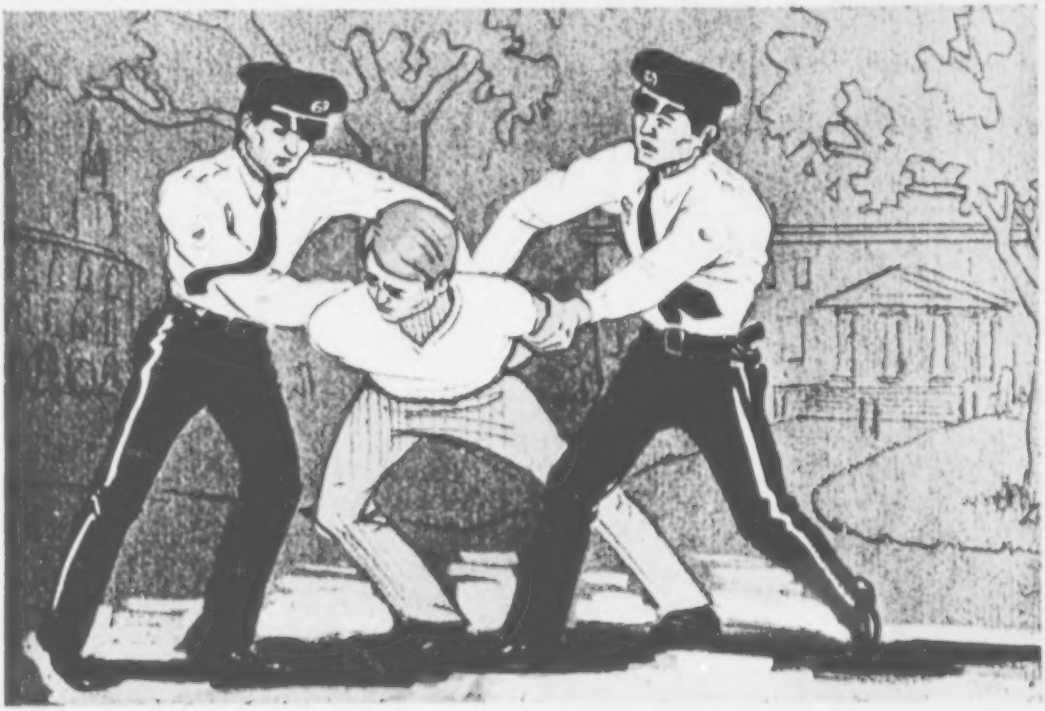
- Strip Search. A thorough examination of a prisoner and his clothing in which his clothing is removed, body openings probed, and all clothing carefully scrutinized.[21]

[21] International Association of Chiefs of Police, The Patrol Operation, 2nd ed. (Gaithersburg, Maryland: IACP, 1974), pp. 227, 228.

The Uniform Act does not alter statutes which permit a police officer to conduct a frisk. In jurisdictions having "stop and frisk" statutes, a law enforcement officer may halt any individual, even if that person is not intoxicated or incapacitated, provided the officer has reason to believe the presence of criminal activity. Further, the officer may also conduct a frisk of the individual if the officer has reason to believe that the person concerned is armed and dangerous. However, in the event a police officer, apart from any other action, only helps an intoxicated person to a treatment facility or other authorized destination or places an incapacitated person in protective custody, the conduct of a frisk is generally not authorized.

It must be remembered that assisting an intoxicated person or taking an incapacitated person into protective custody does not constitute an arrest and does not authorize the carrying out of either a field search or a strip search. As opposed to a frisk, an arrest must be made or a warrant secured before the field search or the strip search may be executed.

Arresting Intoxicated or Incapacitated Persons. There are instances, of course when intoxicated or incapacitated persons should be arrested. Even though it is preferable to substitute a treatment center for a detention facility, there are times when an arrest is not only necessary but mandatory. The police officer should arrest (and search intoxicated or incapacitated persons when they:



- Are endangering other persons or property

- Have committed a criminal offense (to include those involving a vehicle, such as driving while intoxicated, operating under the influence, drunken driving, driving under the influence)

- Are under the combined influence of alcohol and drugs, or
- May be too violent for medical personnel to control

Although incarceration generally follows arrest for persons involved in the situations just enumerated, medical attention sometimes may be necessary in order to evaluate their physical condition, i.e., that they are suffering from the effects of alcohol and not reflecting the symptoms of some other disease or illness. In such situation, every effort should be made to take the arrested person to an emergency treatment center for evaluative purposes prior to detaining him in jail. In any event, the arrestee should be subjected to a medical checkup as soon as possible after being taken into custody.

It must be realized that many inebriates are sick, often from the effects of alcohol as well as other disorders. Only a person with medical training and experience is capable of determining the type of sickness that is present. In the history of many jails is the

incident of the unconscious drunk who was left in a cell overnight to "sleep off" his overindulgence, only to be found dead on the following morning. In most cases, a death of this sort can be attributed to the jailing of an inebriate or one though to be an inebriate without benefit of a medical examination.

It should be noted here that an officer's discretionary authority represents an important factor when consideration is given to arrests involving inebriates. In this regard, if the offense committed by an intoxicated or incapacitated person is a relatively minor one, discretion may allow the officer to place the individual concerned on the path to treatment instead of toward jail.

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As mentioned previously, although an intoxicated or incapacitated person may by his actions be guilty of disorderly conduct, drunkenness, by itself, does not constitute disorderly conduct under the Act. In commenting on Section 1 of the Act, the National Conference of Commissioners on Uniform State Laws stated, in part, that, "The normal manifestations of intoxication—staggering, lying down, sleeping on a park bench, lying unconscious in the gutter, begging, singing, etc.—will therefore be handled under the civil provisions of this Act and not under the criminal law."

Even though it is well established that a police officer may arrest an intoxicated or incapacitated person who is acting in a disorderly manner, a disorderly conduct charge should never be substituted for the revoked offense of public intoxication. In other words, before an intoxicated or incapacitated person may be arrested for disorderly conduct, the elements of that offense must be present.

Whether the elements of the crime of "disorderly conduct" are present in the act(s) of an intoxicated or incapacitated person often requires that a prudent value judgment be made by the police officer concerned. Jurisdictional variances, legal precedent, and local practices also contribute to the difficulty of presenting a precise definition of the crime.

For these reasons, unless local statutes dictate otherwise, a police officer should be guided by the definition of "disorderly conduct" as stated in Black's Law Dictionary:

> A term of loose and indefinite meaning (except as occasionally defined in statutes), but signifying generally any behavior that is contrary to law, and more particularly such as tends to disturb the public peace or decorum, scandalize the community, or shock the public sense of morality.[22]

Criminal or Civil Liability of the Law Enforcement Officer

The drafters of the Uniform Act gave special attention to the difficulty facing a police officer in his effort to determine whether a particular person is, in fact, incapacitated. As a result, a provision was inserted into the Act which protects the officer in the event his evaluation, made in good faith, is found later to be incorrect.

[22]Henry Campbell Black, Black's Law Dictionary, 4th ed. (St. Paul, Minnesota: West Publishing Co., 1951), p. 556.

In this respect, Section 12 of the Act states clearly that police (or members of the emergency service patrol) who act in accordance with this section "...are acting in the course of their official duty and are not criminally or civilly liable therefor." It then follows that if an officer, in good faith, determines an individual to be incapacitated, places the individual in protective custody, and, later, the officer's decision is found to be wrong, then the officer concerned is neither criminally nor civilly liable for false arrest or imprisonment. However, it is again emphasized that the Act employs the phrase "reasonable steps" when speaking of measures to be used in an officer's self-protection. To insure further against the possibility of a criminal or civil liability charge being lodged against him, an officer must never resort to the use of excessive force.

Special or Unusual Circumstances

Although this chapter has attempted to describe (and offer a suggested course of action for) most of the situations which will confront the law enforcement officer acting under the provisions of the Uniform Act, there will be times when special or unusual circumstances may present a problem for which a solution is not readily apparent. In these instances, if exigent action is required, the officer has no alternative; he must act according to his own best judgment.

If, on the other hand, there is time to predict the occurrence of a special or unusual situation—or if it is known in advance that a particular incident will occur—then assistance in the form of advice can be received from a number of sources. If information is sought concerning the legality of pursuing a certain course of action, a query should be directed toward the law enforcement agency's legal advisor. In agencies not having an assigned or part-time legal officer, the item in question should be presented to the city or county attorney for resolution and guidance.

If the issue being considered pertains to an administrative or technical interpretation of the Act's provisions, the matter should be referred to the governor's designated state alcoholism agency, or to its branch office if appropriate. For reference purposes, a listing of state alcoholism authorities and program contacts has been included in this manual as Appendix E. It should be noted, however, that this listing is subject to change. For this reason, law enforcement agencies should arrange with state alcoholism authorities to be placed on the distribution roll for the dissemination of updated information.

CHAPTER V

V

IMPLEMENTATION PLANNING AND TRAINING CONSIDERATIONS

Section 1 - Plans and Planning

General

Planning as well as the preparation of plans is essential to the completeness and success of any worthwhile law enforcement program. Specifically, planning is a continuous action which follows a logical and progressive series of steps (the planning sequence) required to develop a plan. A plan, on the other hand, is a method or proposal for establishing and maintaining a program—it is part of the planning process.

Planning

Planning Sequence. This term refers to the progression of actions required to devise a plan. Each sequential rung in the planning ladder should attempt to anticipate all developments and ramifications that may impact on the program under consideration. Inherent in the law enforcement planning sequence for implementation of the Uniform Act are the following consecutive steps:

- Forecasting. The analysis and evaluation of trends and facts to determine probable commitments and predict developments concerning the Act's impact on the community. Assumptions are fundamental to forecasting and are generally associated with all of the steps which comprise the planning sequence.

  In the absence of facts, assumptions address those conditions that should be present if a particular plan is to be successful. Of course, different assumptions may be used to develop alternate plans. (Example: What course of action should be followed if an approved public treatment facility refuses to admit an intoxicated person?) Forecasts may be changed as additional information becomes available; as various facts become apparent, they should preempt assumptions which are in conflict.

- Evaluating Probable Commitments and Establishing Priorities for Planning Tasks. This step involves an examination of assumptions and commitments which have been predicted to determine not only their probability of occurrence, but also their probable sequence of occurring.[1] It is here that a planning program begins to take shape.

- Studying the Implications and Mutual Relationships of Predicted Commitments to Determine Goals and Objectives.[2] This step results in the determination of desirable objectives so that a comprehensive mission statement[3] may be articulated.

- Examining the Mission Statement to Determine Tasks. Here, specific tasks are decided upon and described. Each task is considered in light of its complexity and importance to the overall program.

- Developing Guidance. In this step, planning guidance is determined for each task that is contained in or implied by the mission statement. Good planning guidance insures a concerted effort on the part of all planners and facilitates concurrent planning by providing information on which to base the development of outline plans.

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[1]Inherent in the completion of this step is the requirement for accurate data collection and statistical analysis, i.e., when and where do public inebriates congregate, why do they gather in a particular area, etc.?

[2]In 1968, after the State of Maryland passed its "Comprehensive Intoxication and Alcoholism Control Act," the Maryland Attorney General issued a memorandum to all police departments and other law enforcement agencies which explained and summarized the provisions of the state act as they concerned those organizations (See Appendix L). By merely reading the Maryland Attorney General's memorandum, the implications and mutual relationships of predicted commitments needed to formulate the mission statement and deduce the attendant tasks are easily determined. Having access to a document similar to this memorandum from their respective attorneys general would facilitate accomplishment of the planning sequence by law enforcement planners in other states. Accordingly, law enforcement officials in states which enact the Uniform Act should request their respective attorneys general to develop and publish a memorandum similar to Appendix L, pertaining to the Act as adopted by the state concerned.

[3]Inherent in the mission statement is an implied task(s) which, together with its purpose, clearly identifies the action to be taken and the reason therefor. It is incumbent upon the head of the law enforcement agency concerned to establish and clarify departmental policy with regard to implementing the provisions of the Act (as adopted by the state in question) as they pertain to police involvement. Once policy is established and the mission is outlined, the resultant task(s) should then be deduced and assigned accordingly.

Planning guidance generally emanates from the following four sources:

1. Oral guidance from the program (alcoholic rehabilitation) director or agency (law enforcement) head

2. Policy statements from the program director or agency head

3. Directives and special instructions from agencies and offices connected with program development

4. Standing Operating Procedures (SOP)

- Preparing Planning Studies. This step is concerned with producing planning studies which pinpoint and analyze the key factors impacting upon program accomplishment. Planning studies are indispensable in determining the feasibility of various approaches to the production of a workable plan.

- Selecting the Best Approaches. Completion of this step should result in a description of the approaches or methods best suited for and most likely to ensure the attainment of stated goals and objectives. Only those courses of action that offer reasonable assurances of success need be considered; however, sufficient courses should be described in order to provide alternatives and flexibility. Ideally, outlines or preliminary plans should be prepared for all reasonable contingencies.

- Preparing Complete Plans. This step is concerned with the preparation of a complete plan for each method of program accomplishment that has survived the test of feasibility and reasonability. Here, the value of the outline or preliminary plan becomes evident as it becomes the framework upon which the complete plan is built.

- Practicing. This step may or may not be taken, depending upon the time required, facilities available, and need for rehearsal. If a rehearsal appears impractical, then implementation training in appropriate areas of the Act should be substituted. "Feedback" resulting from practice sessions or "dry runs" is used to improve upon both current and future plans.

PLANNING
PLANNING SHOULD BE AN INTEGRAL PART OF THE LAW ENFORCEMENT MANAGEMENT PROCESS
TOP MANAGEMENT LOOKS AT RESOURCES, NEEDS, AND OBJECTIVES-
TODAY'S AND THE FUTURE'S
TOP MANAGEMENT DOES THE PLANNING
ALLOW FOR THE USE OF BOTH EMPIRICAL AND SUBJECTIVE DATA
LONG RANGE PLANNING IS A CONTINUAL PROCESS
1
2
ESTABLISH PRIORITIES FOR OBJECTIVES
PLANNING IS A LEARNING PROCESS
UTILIZE FEEDBACK

Agency Planning Organization. The heads of law enforcement departmental divisions (patrol, criminal investigation, support services, administrative, etc.) may be considered as constituting the staff of the police chief, sheriff, or state police superintendent concerned. There are four fundamental ways in which this staff and/or other agency members may be organized for planning purposes.

- Current Organization. Using the existing organization without changing its structure is probably the most preferable method. Here, each staff member or divisional head provides input to the plan, but remains in his regular assignment and office. Coordination is accomplished with other levels of staff and command by correspondence or through visits.

- Permanent Planning Office. Following this method, a specially formed planning office is charged with performing all of the planning—primarily long-range—for the agency. This configuration allows the regular divisions and staff sections to concentrate on short-range planning requirements and current operations. The presence of a permanent planning officer is particularly useful during intense current operations when regularly assigned operational personnel have little time for planning or when current and future operations are not closely connected. Drawbacks to this method of satisfying the planning functions are the requirements for additional personnel and facilities.

- Temporary Planning Office. Often referred to as the ad hoc committee method, this manner of establishing a planning body is employed generally to resolve a particular problem or develop a specific plan. Ad hoc committees are staffed by personnel drawn from the agency concerned. Since during the life of the ad hoc committee these individuals are unable to devote full attention to their primary functions, resort to this method should be made only to relieve a staff from overextending itself or when a special planning effort is required.

- Combination of Methods. The various ways in which an agency may combine its resources using the methods just described are readily apparent. For example, a planning section could be assembled to work on matters of common interest. Then, after the various tasks are completed, the members of the section would return to their normal assignments to prepare their assigned portions of the complete plan within the framework of the existing organization.

Plans

Characteristics of a Plan. In the police planning process, a plan represents a law enforcement agency's preparation:

- In a particular area
- To accomplish a specific program

In the case of planning for police implementation of the Uniform Act, the particular area is that of providing assistance to inebriates. The specific program to be accomplished is to participate in and cooperate with alcohol education and treatment programs.

Plans may be oral or written; they are kept current by subjecting them to a continuous system of estimates, analyses, and studies as provided for in the overall planning process.

A plan must describe a particular best approach toward the attainment of an objective, and it must outline the best means for attaining that objective. A well-structured plan:

- Provides for program accomplishment—the basis for all planning
- Is based on facts and/or a minimum of well-grounded assumptions
- Uses existing resources to realize its objective
- Structures the organization necessary to accomplish the program, establishes relationships, and assigns responsibilities
- Establishes continuity of operations, i.e., describes the organization, material, personnel, and other means which are needed to carry the program throughout its lifetime
- Provides for decentralization and delegation of authority within reasonable bounds of control
- Authorizes direct contact between various staff and command levels necessary for program-attainment

- Is simple—eliminates nonessential elements and possibilities which may lead to misunderstanding

- Describes alternate approaches and ensures flexibility by allowing for necessary adjustments

- Provides for control procedures which channel the plan's execution in consonance with stated policy

- Provides for external and internal coordination by ensuring continuity of effort, completeness of control measures, and adequacy of support requirements

Standing Operating Procedure (SOP). Although not a plan in the strict sense of the word, an SOP outlines planned action which, when initiated, offers an individual(s) the best approach toward the objective for which the SOP was designed. The purpose of an SOP is to describe those procedures which are essential and peculiar to the particular operation or task being addressed. An SOP lists, preferably in chronological order, those methods which are employed habitually to accomplish routine or recurring actions. The use of SOPs:

- Reduces the number and types of other directives

- Simplifies training

- Enhances understanding and teamwork among other divisions or sections within an organization

- Apprises newly assigned personnel of the procedures to follow under a certain set of circumstances

- Facilitates efficiency and expedites operations

- Reduces the possibility of error, omission, and confusion

- Simplifies the preparation, promulgation, and execution of other directives

Written SOPs are exceptionally well-suited vehicles to use in establishing the procedures to be followed in the handling of intoxicated and incapacitated persons according to the

provisions of the Uniform Act. Today, whether due to oversight, lack of interest, or ineptness, there are law enforcement agencies operating under the Act which have not set forth written instructions on processing the public inebriate. The SOP is not merely a desirable document to have, it is a necessary document—necessary if a police department wishes to reach its objective of providing assistance to the alcoholic person as provided for in the Uniform Act.

An SOP should be detailed and exact. If the writer considers some point too insignificant or too well-known to include in an SOP, it is most likely that the point being considered is the one that, if omitted, would render the entire directive useless. The premise that "everyone knows that this (or that) should be done now (or then)" is erroneous; it is to validate this proposition that the SOP is needed and should be developed.

The language of an SOP should be characterized by accuracy, conciseness, and lucidity. Effective writing conveys the author's exact meaning and is not subject to misinterpretation. The following basic principles of good communication should be observed during the preparation of an SOP:

- Accuracy: factual, errorless
- Brevity: simple words, short sentences
- Clarity: simple and clear
- Coherence: logical arrangement of subject matter (follow processing sequence)
- Completeness: explore all contingencies
- Objectivity: develop an impersonal approach to the subject
- Unity: stay on the same track, do not deviate from the main idea[4]

[4]Drug Enforcement Administration and International Association of Chiefs of Police, Guidelines for Narcotic and Dangerous Drug Evidence Handling and Security Procedures (Washington, D.C.: U.S. Government Printing Office, 1974), pp. 18, 19.

In police parlance, SOPs are sometimes referred to as procedural plans. These plans include all procedures that have been outlined and adopted as officially approved methods of operation to be followed under various conditions—regardless of circumstances. These procedures remain in effect unless higher authority directs otherwise.

Method of Publication and Issuance. Organizational direction may be defined as the method used to guide or regulate the personnel and other resources of an agency. All available resources are involved in the process of direction, but it is primarily that portion of the management process which involves interpersonal relationships that are vitally affected by motivation, leadership, and communication. Direction is accomplished primarily by the publication and issuance of directives, by periodic staff conferences, and by interpersonal relationships between superiors and subordinates.

After considering pertinent legal provisions and any sanctions which may be imposed by higher authority, the chief of police (sheriff or other law enforcement agency head) should, on his own initiative, establish a system for the publication and issuance of written directives (general orders, SOPs, special orders, personnel orders, training bulletins, memoranda) to assist in the direction of the agency.[5] Daily bulletins should also be published. The department's administrative or planning section should have overall coordination responsibility for the preparation and issuance of all written directives. Of course, sections having the primary interest in any particular directive should have general responsibility for the directive's content, i.e., general responsibility for the publication of training bulletins should fall within the purview of the training section.

Written directives should be used in preference to oral direction whenever feasible since they have the quality of permanence and the wording of such directives remains unchanged over periods of time. Written directives are less subject to misinterpretation since they are disseminated to personnel throughout the department, divisions, or units, as the case may be. When properly controlled, written directives constitute virtually unassailable evidence of the assignment of duties and responsibilities, a factor which should be considered because of today's legalistically oriented disciplinary procedures. In addition, written directives can be utilized by intermediate echelons of supervisors as resources in the training of their subordinates.

Uniformity in the general format of orders promotes readability and aids individual understanding of the contents. It is indicative of an orderly and systematic approach to management direction.

Each directive should be coded so that related orders can be assembled in separate sections of a general duty manual. This manual should contain all general orders in a

[5]O. W. Wilson, Police Planning, 2nd ed. (Springfield, Illinois: Charles C Thomas, Publisher, 1971), p. 261.

codified form, SOPs, and existing rules and regulations. The manual should also contain an alphabetical index, a control code index, and a lettered section index. All personnel should receive copies of written directives and should be held responsible for keeping them up-to-date in their own general manual and for carrying out the provisions of all applicable directives. The manual should be separated into subject matter by sections, such as: administration, personnel, training, operations, services, public relations, liaison, and legal.

One of the problems associated with the implementation of a new written directives system is the time it takes to prepare a "manual." The preparation of even a relatively small number of directives is time consuming, and ultimately many orders will have to be prepared to establish proper administrative and operational procedures. To delay the publication of the department's general duty manual until these many orders are completed will seriously impair its value. It is important that the system be implemented by the publication of a first general order. The second and subsequent orders should follow rapidly and regularly until the manual is deemed to be completed. Actually, a good written directives system is never completed in the ordinary sense of the word. It is a fluid and viable process which must reflect current management policies and practices. If the directives system becomes static, it will, in this era of rapid change, become quickly dated and not reflective of current conditions.

Control of the issuance and retention of written directives requires that each member of the department be given a personal copy of each such order as it is issued. A master list of all members and employees of the department should be prepared for each directive, and each person should be required to sign for his copy upon receipt. When the list has been completed, it should be returned to the planning or administrative section for retention in the files of that unit. Personnel should be required to update their manuals as necessary. Manuals should be inspected from time to time to insure that they are current.

The correct indexing of written directives makes them more readily available for reference and use. As the number of orders increases, an index serves as a valuable cross-reference. It is particularly important that a master copy of all written directives be maintained in the planning or administrative section. This standard copy should be used whenever there is any question as to the date and authenticity of any established directive.

Jurisdictional Planning

In addition to the conduct of planning activities within the law enforcement agency itself, the agency head should ensure that his department participates in jurisdictional planning. To a police chief, jurisdictional planning has three connotations. The term may refer to:

- Interagency planning among law enforcement agencies which are geographically close, or operate generally within the same

geographical boundaries, or participate jointly under a mutual aid agreement, or which should operate together in a combined or regional police effort;

- Agency planning responsibilities connected with police or other regional or state planning agencies; or

- Cooperative agency planning with other governmental agencies or subdivisions within the jurisdiction of interest.

Regarding the latter type of jurisdictional planning—and that of main concern here—the National Advisory Commission on Criminal Justice Standards and Goals has this to say:

> 5. Every police agency should participate in cooperative planning with all other governmental subdivisions of the jurisdiction when such planning can have an effect on crime, public safety, or efficient police operations.
>
> a. Every local governmental entity, in all matters of mutual interest, immediately should provide for police planning with that of other governmental subdivisions of the jurisdiction.
>
> b. Every police agency should assign responsibility for such planning immediately. This assignment should include at least the responsibility for joint planning, when applicable, with the local government administrative office, local government attorney's office, finance department, purchasing department, personnel department, civil service commission, fire department, department of public works, utilities department, building inspection unit, street or highway department, parks department, recreation department, planning unit, and health department (emphasis supplied.)[6]

[6]National Advisory Commission on Criminal Justice Standards and Goals, Report on Police (Washington, D.C.: U.S. Government Printing Office, 1973), p. 123.

Cooperative (Joint) Agency Planning.[7] Cooperative agency planning and Uniform Act implementation should be closely affined especially where law enforcement agencies, health departments and facilities, and the state division of alcoholism are concerned. In this respect, special attention should be given to Section 5 of the Uniform Alcoholism and Intoxication Treatment Act which addresses the duties of the state agency responsible for planning activities with regard to alcoholism. Police executives should become familiar with the contents of this section because it contains a number of subsections which are of particular interest to police agencies involved in planning activites related to the Act and its impact on law enforcement operations.

Although these subsections may be reviewed in Appendix B, they are listed here because of their importance to the police planner and for ease of reference:

SECTION 5. (Duties of Division.) The division shall:

(1) develop, encourage, and foster statewide, regional and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the (department of correction and board of parole) in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the (department of education), (boards of education), schools, police departments, courts and other public

[7] Ibid., p. 127. This footnote refers to the following: "Many local and State governments have no provision for joint planning between subdivisions. In some cases, department heads meet and confer regularly, thus providing general unity of direction. Representatives from two or more departments often will meet to plan for a specific event. But this is not enough. What is needed is an established means for police planning in conjunction with other subdivisions. Every police chief executive should assign qualified personnel specific responsibility for joint planning with each subdivision of government that shares reciprocal interests with the police agency."

and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of school education;...

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;...

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the Governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the State's comprehensive health plan;...

(14) cooperate with (the commissioner of public safety) (highway commission) in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while (intoxicated);

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;... (emphasis added in all cases)

As may be seen from this excerpt, it is incumbent upon the state division of alcoholism to initiate the development of state, regional, and local plans in implementation of the Uniform Act's provisions. Also, according to the Act, cooperative and coordinative efforts should be initiated by the respective state division of alcoholism.

Although this latter conclusion is easily deducible from the language—"The division (of alcoholism) shall..."—of the Act, implementation may not follow automatically or it may assume forms other than that specified or intended. For these reasons and in the interests of furnishing effective police support to the community, it is incumbent upon law enforcement authorities to ensure that planning programs involving the delivery of police services are, in fact, initiated and sustained.

[8]Uniform Alcoholism and Intoxication Treatment Act, 1971 (Appendix B).

What has just been stated should not be construed as implying that police officials should encroach on the planning domain assigned to others. Neither is it meant to infer that the police assume additional responsibilities—it is meant, however, to emphasize the need for police initiative and involvement necessary to the success of jurisdictional planning attendant to the enactment of the model law.

As mentioned in Chapter IV, law enforcement authorities are not given sufficient voice in or accorded adequate representation on jurisdictional alcoholism planning boards or commissions.[9] It is in instances such as these, potential or real, that the law enforcement official concerned must express his views relative to police participation in the planning effort.

Conversely, when law enforcement representatives are placed on alcoholism planning or advisory groups, they must engage actively in the proceedings and accept the responsibilities which are assigned to them. Any lesser response will not only alienate the other members, but will derogate or impede implementation of the Act's provisions in the community being served.

Considerable thought should be given to the type of police representation that should be appointed to planning boards or advisory groups. Such representation should not be looked upon as figurehead or "somebody has to do the job" types of appointment. In the first place, the commission or board should be thought of as a "working group" and not as a theory-producing "discussion group." Accordingly, the individual appointees (agency representatives) should be selected from the ranks of operationally oriented individuals, i.e., planners or uniformed division[10] commanders.

Agency Planning. Planning activities carried on within a police department fall generally within two categories:

- Administrative planning refers to the development of plans concerned with providing direction and support. Administrative planning should be designed to expedite operational functions and should deal primarily with management type plans addressing subjects such as fiscal matters, budgeting, and records-keeping. Generally, administrative plans are long-range in nature and are based on operational requirements.

- Operational planning refers to the development of plans that outline courses of action to be taken to accomplish a particular commitment or satisfy a specific requirement. Operational planning implies the formulation of a plan of action—either short- or long-range

[9]Some state, regional, and local alcoholism plans make little or no reference to the law enforcement role which is essential to the program's success.

[10]The organizational entity in a law enforcement agency concerned which performs the preponderance of patrol or "street" duty.

—and encompasses tactical, procedural, and specific operational planning. In a law enforcement agency, planning activities associated with responsibilities emanating from enactment of the model law would be categorized as operational planning.

In discussing agency planning, Report on Police states, in part, that:

> Every police agency should develop planning processes which will anticipate short- and long-term problems and suggest alternative solutions to them. Policy should be written to guide all employees toward effective administrative and operational planning decisions. Every police agency should adopt procedures immediately to assure the planning competency of its personnel through the establishment of qualifications for selection and training.
>
> 1. Every police agency should establish written policy setting out specific goals and objectives of the planning effort, quantified and measurable where possible, which at least include the following:
>
> a. To develop and suggest plans that will improve police service in furthering the goals of the agency;
>
> b. To review existing agency plans to ascertain their suitability, to determine any weaknesses, to update or devise improvement when needed, and to assure they are suitably recorded;
>
> c. To gather and organize into usable format information needed for agency planning...[11]

In particular, when drawing up operational plans, law enforcement agencies should familiarize themselves with community organizations and groups whose activities are likely to impact on police operations. Accordingly, when appropriate, representatives of these organizations should be afforded an opportunity to participate in the planning for the provision of police services whenever the resultant plan will affect a particular community group or organization. Illustrative of the types of activities that may become involved in the police planning process are service clubs, social groups, civic and political organizations, educational and medical institutions, professional and vocational associations, labor unions, business groups, and others as necessary or appropriate.

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[11] National Advisory Commission on Criminal Justice Standards and Goals, Report on Police (Washington, D.C.: U.S. Government Printing Office, 1973), p. 117.

Operational Planning and the Uniform Act. Of the three general categories of operational plans (tactical, procedural, and special operational plans), the procedural plan—established as the approved method of operation under given conditions or set of circumstances—is the type that should be developed to set forth the manner of accomplishment for departmental objectives relative to police duties and responsibilities under the Uniform Act. The operational plan should prescribe the vehicle to be used (general order or SOP) in disseminating the plan's content throughout the agency and should contain a copy of the order or SOP.[12] Ideally, the plan should also include a provision for the publication of a small pocket-size brochure which outlines the responsibilities of police officers with respect to the Uniform Act. Until they become familiar with their duties under the Act, police officers could use the pamphlet as a ready reference.

As a minimum, the plan should address the topics outlined in Section 3, Chapter IV, of this manual and should include the more important definitions such as "intoxicated person" and "incapacitated person." In the plan, emphasis should be given to the following areas as they pertain to the form in which the Act is adopted by a particular state:

- Determining whether a person is "intoxicated" or "incapacitated"
- Actions upon determining an inebriate's condition
- The meaning of "transportation forthwith"
- Emergency service patrols (rescue teams)
- Denial of admission to treatment facilities[13]
- Police assistance at a public treatment or emergency medical service facility

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[12]In some jurisdictions, the plan is written in the form of an order or SOP so, that upon approval, it can be published immediately, without change. This method saves time and money as it eliminates the process of transforming the plan into another directive, i.e., an order or SOP, before it can be distributed and implemented.

[13]Plans should make provision to preclude denials of admission because of overcrowded conditions (as opposed to other reasons) by establishing a system requiring hospitals to notify local law enforcement agencies of probable critical space capacities before the actual situation develops. Knowing of this probability or actuality, a police department can then route officers transporting inebriates to alternate treatment facilities. Proper authority should be informed if a hospital makes a practice of denying admissions to intoxicated or incapacitated persons because of overcrowded conditions.

- Use of force
- Searching intoxicated or incapacitated persons
- Arresting intoxicated or incapacitated persons
- "Disorderly conduct" and "private drunkenness"
- Civil or criminal liability of the law enforcement officer
- Handling of juveniles
- Legal and administrative assistance available to law enforcement officers

Agency operational plans must reflect the situation as it exists in the community of interest. Plans should not be vague or require an officer to perform impossible duties, i.e., require transport of an intoxicated person to an alternate site when, in fact, no such alternate site exists. If procedural-type plans require that nonexistent procedures be followed, the officers who are expected to execute the plan will soon discover its weaknesses and pay only lip service to it.

Section 2 - Training

General

In contemporary society, the police officer must make decisions that have far-reaching effects on the entire community he serves. It is the virtually unanimous opinion of professional police administrators, civic officials, and informed laymen that improved police service in the United States can come only when police officers are better educated and trained. The purpose of education in the police service is to make the police officer a more fully rounded person with a broader understanding of the social problems with which he comes into contact. The purpose of training is to improve the ability of police officers to make correct decisions and to take appropriate action at the right time.

To gain experience with regard to actions to be taken by a law enforcement officer in accordance with the terms of the Uniform Act, police training designed to explain the Act's meaning and its impact on police operations should provide for the conduct of

practical exercises. The introduction of practical exercises into the training program will also satisfy the last phase ("practicing") of the planning sequence (see page 81).

Training Program[14]

Instruction in the provisions of the Uniform Act can be injected into all of the following types of training which are fundamental to a well-structured police training program:

1. Pre-Service Training. Efforts should be made to recruit personnel who have prepared themselves for police service by acquiring college or university training in police science or the behavioral sciences.

2. Initial Recruit Training. This training should be provided by police academies after entrance into the service. It should be given before recruits are assigned to duty. It should provide all of the basic knowledge necessary for the competent performance of police tasks.

3. Roll-Call Training. About 10 minutes of training on a selected topic should be given to each shift during roll call. Because of the short time period, roll-call training should be developed in advance and should make use of prepared training bulletins, slides, and short lectures.

4. In-Service Training. Periodic retraining is necessary for proficiency in the skills not used on a daily basis. In-service training should also be planned to keep all members of a department abreast of the latest trends, methods, and problems.[15]

5. Advanced or Specialized Training. These programs should be designed to prepare police personnel for duties of a specialized nature or for supervisory positions.

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[14]A suggested training program is outlined in the Law Enforcement Guidelines Instructor's Manual which has been published as a supplement to this manual.

[15]In-service training should include practical exercises. During periods of relative inactivity, there should be "practice runs" to promote teamwork and supervision. Patrol procedures often are taken for granted after recruit school, but they include many techniques that should be reviewed at intervals. Subjects worthy of periodic review include prowler calls, civil disputes, domestic disturbances, mentally disturbed persons, handling of children, handling of military personnel, mechanics of arrest, handling of intoxicated and incapacitated persons, field interviews, and the proper method of stopping a suspect vehicle.

There should be continuous direction and overall coordination of a police agency's training programs. Training should be provided on the basis of what the department and the community need from their police officers. All police training is expensive. Even where there is no tuition cost, the community must still pay an officer's salary while being deprived temporarily of his service. Course content and teaching techniques should be carefully scrutinized by departmental training officers to insure that each subject is covered adequately and taught effectively.

Training sessions which are conducted in explanation of and to describe actions to be taken under the provisions of the Uniform Act should be accorded priority according to time available and importance of subject matter. In this latter regard, procedures should be given to those need-to-know areas listed earlier in this chapter under "Operational Planning and the Uniform Act." Later, when time permits, nice-to-know items such as the Act's background and highlights of interest can be discussed.

Quality Control of Instruction

Each police agency should ensure that instructional assignments are handled by competent, knowledgeable individuals and that training materials are updated continually. Addressing these points, Report on Police recommends:

a. Periodic monitoring of the presentations of every police training instructor to assist him in evaluating the effectiveness of his methods and the value of his materials;

b. Rotation of police training instructors through operational assignments or periodic assignment to field observation tours of duty;

c. Use of outside instructors whenever their expertise and presentation methods would be beneficial to the training objective;

d. Continual assessment of the workload of every police training instructor; and

e. Administrative flexibility to insure efficient use of the training academy staff during periods of fluctuation in trainee enrollment.[16]

[16]National Advisory Commission on Criminal Justice Standards and Goals, op cit., pp. 409, 410.

and

> Every police agency and police training academy should review all training materials at least annually to determine their current value and to alter or replace them where necessary.[17]

Persons assigned on a full-time basis to the training function sometimes tend to lose contact with the realities of line operations. Each permanent member of the training staff should be assigned to line functions for at least two weeks each year. This type of in-service program will allow training personnel to obtain first-hand knowledge of the problems faced by patrol, traffic, and investigating officers.

Although there is some controversy among law enforcement personnel concerning the value and competence of utilizing instructors from without the police department, i.e., nonpolice instructors, instruction concerning the Uniform Act lends itself considerably to the use of outside experts.

Departmental opposition to the use of nonpolice instructors is voiced generally because of their well-meaning but sometimes alleged disorganized and otherwise ineffective lectures. Also, it is felt that the department has little control over the material presented by guest lecturers and that student attention and discipline are often lacking during these sessions. Some police departments hold that material handled by outsiders is considered by the training staff to be either inconsequential or controversial.

The sentiments just described are in direct opposition to those held by progressive police administrators and should not be allowed to interfere with instruction associated with explaining the Uniform Act to law enforcement officers. Police authorities should work toward achieving training objectives by employing all available resources. In this regard, nonpolice instructors are often more proficient in certain areas than police instructors. Often their educational and occupational experience will relate directly to a specific area such as that covered by the Uniform Act. Individuals assigned to state or local alcoholism agencies, attorneys, health and medical personnel, probation officers, psychologists, and laboratory technicians are a few sources of valuable expertise[18] with respect to instruction concerning the model law.

A fringe benefit that may materialize from the use of outside instructors is the possibility that they may be able to better emphasize the need for agency and group coordination and cooperation in implementing the Act's provisions. Positive statements and attitudes voiced or reflected by others help to strengthen unity of purpose within the community and thereby enhance goal accomplishment.

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[17] Ibid., p. 410.

[18] Ibid., p. 414.

CHAPTER VI

VI

CONSIDERATIONS CONCERNING THE HANDLING OF INTOXICATED OR INCAPACITATED PERSONS

General

In probably no other encounter between a law enforcement officer and another individual is there such a diversity of consequences, actual or potential, as may result from a meeting of an officer with an inebriated person. Primary among the numerous reasons for this circumstance is the unexpected or unpredicted behavior that is or may be exhibited by individuals because of their consumption of alcoholic beverages.

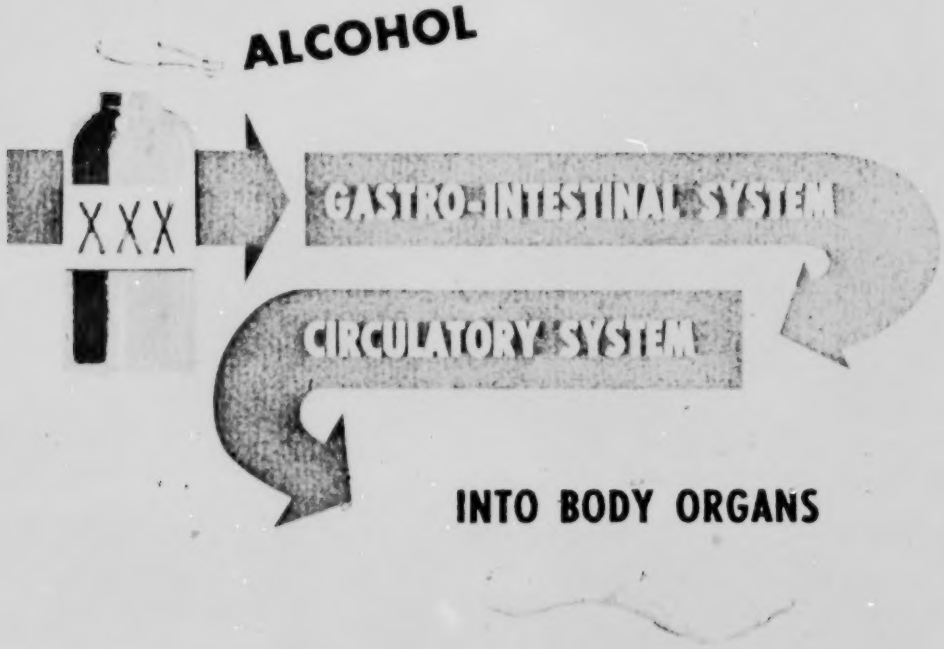
Accordingly, it is necessary for the police officer to become familiar with various displays of atypical conduct and erratic demeanor which may confront him while performing duties in support of police responsibilities connected with the Uniform Act. Presented in this chapter, therefore, are descriptions of some of the more common manifestations of intoxication and incapacitation due to alcoholic beverage consumption. Also included is a discussion of certain physical conditions or behavioral attitudes which resemble those produced by alcoholic intoxication, but are actually symptoms of another illness or injury.

Process of Intoxication

When alcohol is swallowed, absorption into the blood is rapid. Alcohol is one of the few substances which the body can absorb directly into the blood stream from the stomach without the process of digestion. Like other foods, however, most of the alcohol quickly enters the blood stream from the intestinal tract. First signs appear from five to 11 minutes after ingestion while the peak level in the blood is observed from one-half to two hours later depending largely upon the volume of alcohol consumed. The distribution of alcohol through the body is accelerated by its tendency to dilate the blood vessels for quicker passage to all parts of the body. Within a matter of minutes, a balance is attained between the alcohol content of the blood and that of the various organs.

The rate of entrance of alcohol into the blood stream depends upon the concentration of alcohol swallowed. The higher the alcoholic content, the faster becomes the absorption. The presence of food in the stomach delays the absorption of alcohol into the blood stream. Milk is more effective than any other food in slowing up the rate of absorption. The fat

content in milk delays the entrance of alcohol into the small intestine where the most rapid absorption takes place.



After absorption into the blood stream, alcohol passes through the liver, the right heart, the lungs, the left heart, and via the arterial blood-flow to all the organs of the body.

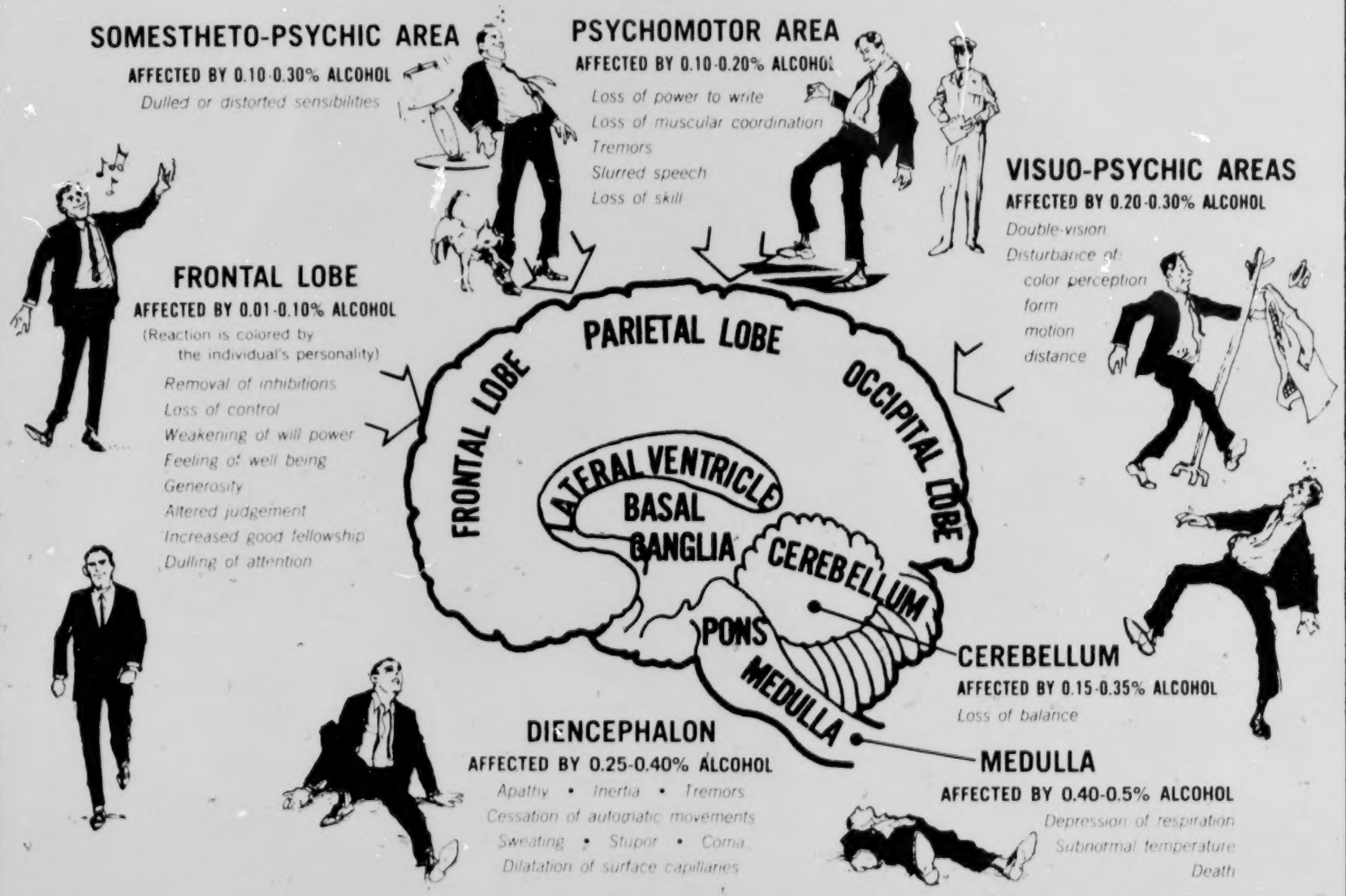
Alcohol and the Brain

The higher functions of the central nervous system such as judgment, self-criticism, and socially acquired inhibitions are first to be affected by the ingestion of alcohol. The alcohol in the brain interferes with the efficient transmission of nerve impulses to the muscles and results in erratic muscular response. This impairment may range from a simple and almost unnoticeable decrease in muscular efficiency to complete temporary paralysis. Deterioration of muscular efficiency may be observed first in handwriting, arm steadiness, speech, and muscular coordination.

The operation of the various sense organs is also affected by the blood alcohol content. A person having a high level of blood alcohol (0.20 percent to 0.30 percent) suffers from diplopia (double vision). However, alcohol concentrations as low as .074 to .124 percent affect visual acuity (sharpness).[1] One effect may be compared to driving with

[1] A. R. Lauer, The Psychology of Driving (Springfield, Illinois: Thomas Publishers 1960), p. 132.

THE EFFECT OF ALCOHOL ON THE BRAIN



sun glasses at night. The eyes lose their sensitivity to light and stronger illumination is required to distinguish objects. The senses of taste, smell, and touch are also impaired.

The vital centers are the last to be affected. Those controlling breathing, pulse rate, and blood pressure become impaired when the blood alcohol level reaches approximately 0.40 percent to 0.50 percent. If medical treatment is not obtained, death is likely to result from respiratory failure and shock associated with low blood pressure.

Listed below are the blood alcohol percentages present in the human body which cause various degrees of intoxication or incapacitation:

Percentage of Alcohol/Probable Result	Probable Condition[2]
0.01 to 0.10 Percent Alcohol	Intoxicated[3]
Loss of inhibitions	
Weakening of will power	
Feeling of well-being	
Generosity	
Altered judgment	
Increased good fellowship	
Dulling of attention	
0.10 to 0.20 Percent Alcohol	Intoxicated
Loss of muscular coordination	
Loss of ability to write	
Tremors	
Slurred speech	
Loss of skill performance	

[2]According to Uniform Act definitions and depending upon an individual's rate of absorption, weight, tolerance, and ability to excrete or oxidize (burn) alcohol in his body.

[3]Reactions to alcohol in this stage of intoxication are often influenced by the personality of the individual concerned.

Percentage of Alcohol/Probable Result	Probable Condition
0.10 to 0.30 Percent Alcohol	Intoxicated
Dulled or distorted sensibilities	
0.15 to 0.35 Percent Alcohol	Intoxicated
Loss of balance	
0.20 to 0.30 Percent Alcohol	Intoxicated
Double vision	
Difficulty in perceiving -	
Form	
Motion	
Distance	
Color	
0.25 to 0.40 Percent Alcohol	Intoxicated/Incapacitated
Apathy	
Inertia	
Tremors	
Loss of reflex action	
Sweating	
Stupor	
Coma	
Dilation of surface capillaries	
0.40 to 0.50 Percent Alcohol	Incapacitated
Depression of respiration	
Subnormal temperature	
Death	

Alcoholic hallucinosis and delirium tremens are also phenomena experienced by the alcoholic person. These conditions are often complications occurring during the "hang-over" stage. Nevertheless, they may also take place during prior states of inebriation.

Elimination of Alcohol

Although alcohol is readily absorbed by the human body, the process of elimination is slow. Therefore, when drinks are consumed too rapidly, the content of blood alcohol will rise faster than the body can eliminate it. A 150-pound man eliminates alcohol at the rate of about one ounce of 100 proof alcohol or 0.02 percent of blood alcohol per hour.

The body rids itself of alcohol through the processes of oxidation and excretion. Oxidation accounts for about 90 percent and excretion from two to 10 percent. The process of oxidation occurs primarily in the liver, although other body tissues are also involved in this process of changing the alcohol into water and carbon dioxide. Excretion of alcohol may either be by breathing, urinating, or perspiring.

Symptoms Often Mistaken for Drunkenness

Determining whether a person is intoxicated or incapacitated because of alcoholic influence or whether he is suffering from another illness or injury often presents a problem to the law enforcement officer. The problem is generated because of the similarity between symptoms of alcoholic intoxication and those evidenced by other, unrelated illnesses or injuries. It is possible for a person to smell of alcohol (either from

drinking an alcoholic beverage or because of another, entirely unrelated reason[4]), stagger, appear drunk, or lie unconscious in a seemingly drunken condition, yet be neither intoxicated nor incapacitated because of overindulgence in alcoholic beverages. For these reasons, a law enforcement officer should be familiar with certain of the following more common conditions which exhibit bodily signs resembling those associated with drunkenness:

- Diabetes. Diabetics may evidence symptoms closely resembling intoxication or incapacitation such as belligerency, slurred speech, staggering, convulsions, and unconsciousness.[5]

- Head Injury. Blows or kicks to the head are not easily discernable upon a cursory examination and often result in the presence of symptoms similar to those associated with alcoholic intoxication or incapacitation.

- Epilepsy. Epileptics may become violent for short periods of time. Also, they may wander about in a confused state for an extended period of time.

- High Blood Pressure. An individual suffering from acute high blood pressure may, from time to time, show signs of irrationality.

- Uremia. This disease of the kidney produces a severe toxic condition—vomiting, convulsions, and coma can result.

- Degenerative Diseases and Conditions. Degenerative diseases such as paresis (syphilitic psychoses) and conditions such as senility (senile psychosis) may cause numerous symptoms similar to those produced by alcoholic intoxication.

- Apoplexy or Stroke. These conditions are due to interference in the circulation of blood in the brain and can result in confusion, dizziness, vomiting, and unconsciousness.

- Brain Infections. Brain infections, tumors, abscesses, and other mental conditions may cause behavior abnormalities, convulsions, or unconsciousness.

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[4]See Appendix I, "Diabetes."

[5]See Appendix I, "Diabetes."

- Carbon Monoxide Inhalation. Poisoning from breathing carbon monoxide gas can cause nausea, dizziness, staggering, coma, and, often, death. A cherry-red coloring of the body usually accompanies the latter progress of this condition.

- Narcotic Intoxication. Drug users and addicts may appear to be in a drunken condition, drowsy, or asleep. They harbor delusions of persecution, have poor memories, and lack social and ethical values when deprived of drugs. If the use of drugs has resulted in an overdose, coma and death can result.

In addition to the conditions or symptoms listed above, other pathological states have symptoms in common with alcoholic intoxication, such as:

Acetone or Fruity Odor of the Breath

In addition to alcoholic intoxication, this may indicate:

- Concussion of the brain
- Diabetes
- Food poisoning
- Stomach cancer
- Stomach ulcer
- Severe migraine headaches

Amnesia or Loss of Memory

In addition to alcoholic intoxication, this may indicate:

- Insanity
- Epilepsy
- Hysteria
- Toxemia (blood poisoning)
- Head injuries

Eye Disorders

Bloodshot eyes and pupils that do not contract or dilate have often been named as indicators of alcoholic intoxication. However, particular care should be given to examination of the eyes; witnesses have been known to testify that a glass eye was "bloodshot."

In addition to alcoholic intoxication, bloodshot eyes may indicate:

- Foreign body in eye
- "Pink eye"
- Hay fever or similar allergic disorders
- Sunstroke

Flushed Face

In addition to alcoholic intoxication, this may indicate:

- Stroke
- Hardening of the arteries
- Fright
- Shock

The conditions and symptoms just described should be taken into consideration by a police officer whenever he observes an individual behaving in an uncommon manner or lying in an unconscious state. Officers must be alert to the possibility that a person appearing to be intoxicated or incapacitated in the sense of the Uniform Act could be physically or mentally ill (See Appendix J, "Severe Mental Illnesses") and in need of prompt medical attention.

Alcohol and Crime

The relationship between criminal acts and alcohol is complex and involved with many other circumstances. It cannot be stated unequivocally that alcohol is a cause of crime. It is true that the ingestion of alcohol may contribute to the commission of criminal acts and cause many problems for the law enforcement officer—one needs only to look at incidents which involve drunkenness such as domestic quarrels, street fighting, or

traffic accidents. On the other hand, inebriates, themselves, are often the victims of crimes or accidents. Therefore, if only for the reasons just enumerated—

(a) Police officers should be fully aware of the potential, physical and mental effect of varying amounts of alcohol in the body; have some understanding of the different diseases or conditions which may mimic the usual symptoms of alcohol intoxication; and know how to recognize the danger signs of alcohol intoxication (coma) or the hangover stage.

(b) The police officer should determine whether or not the person is in such a state as to be capable of hurting himself or others. If the individual does seem potentially dangerous, he must be taken into custody or protected.

(c) If the drunken person has to be jailed, the officer should ensure that the prisoner is watched at frequent intervals, in case intoxication should increase to possibly dangerous levels.

(d) In any kind of comatose condition, where the prisoner cannot be aroused, police should call a doctor or try to get the victim to a hospital. If the coma lasts longer than a few hours, there are probably more complications than just alcohol.

(e) The police officer should be fully aware of the disease of alcoholism and its possible complications.[6]

The police officer must remember that he is not expected to fulfill the function of a psychologist or physician. However, to meet the responsibilities of his office, he should make every attempt to distinguish between those intoxicated or incapacitated by alcohol and those whose problems emanate from another type of illness or injury.

Knowing how to handle properly each case, the police officer can help these persons immeasurably. In any event, the situation will not be compounded or contribute to the subject's death.

[6]The Correctional Association of New York and the International Association of Chiefs of Police, Alcohol and Alcoholism (New York: The Christopher D. Smithers Foundation, Inc., undated), p. 31.

APPENDIX MATERIAL

APPENDIX A

DEFINITIONS

DEFINITIONS

The terms listed below are defined or described in the context of their usage in the text or in the Uniform Act. Definitions of other relevant words or terms used in the text may be found in SECTION 2. (Definitions.) of the Uniform Act (Appendix B).

Detoxification Center/Facility

A generally informal or popular term used to indicate an agency or facility that provides emergency treatment to an intoxicated or incapacitated person. Admittance to this facility is normally the first step in the actual treatment program after an inebriate has been assisted or transported to the center. Caution should be exercised in the use of this term as it may carry the connotation of referring to a free-standing facility clearly marked "Detoxification Center" and be thought of as the only place that an inebriate may be taken. Actually, any hospital emergency room may serve the function of detoxifying an inebriate—although the emergency room itself will probably not be labeled as a "detoxification center."

The Uniform Act employs the term "emergency treatment," "emergency medical service," or "approved public treatment facility" in lieu of "detoxification center." Here, the rationale is largely based on the supposition that the term "detoxification" tends to stigmatize alcoholics and inebriates and set them apart from persons suffering from other illnesses, or it may cause others to look upon "detoxification" as the only treatment available or given to inebriates—and then merely as a replacement for lodgment in a detention facility. In the same vein, it is felt that the use of the word "treatment" further identifies alcoholism and intoxication as a health problem.

Inebriate

A person who is drunk; an habitual drunkard. In the text, an inebriate may refer to an intoxicated person or an incapacitated person.

Protective Custody

The charge or control exercised over an individual by a person or general authority in order to shield (guard) or cover the individual concerned from injury or harm, inflicted either by himself or others. Normally, protective custody is not considered to be an arrest in the judicial sense; nor is it considered so in the sense of the Uniform Act.

APPENDIX B

UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT
(with comments)

1971

UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

(WITH COMMENTS)

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS EIGHTIETH YEAR
AT VAIL, COLORADO
AUGUST 21–28, 1971

SECTION 1. [*Declaration of Policy.*] It is the policy of this State that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

COMMENT

This section is intended to preclude the handling of drunkenness under any of a wide variety of petty criminal offense statutes, such as loitering, vagrancy, disturbing the peace, and so forth. As the crime commissions pointed out, drunkenness by itself does not constitute disorderly conduct. The normal manifestations of intoxication—staggering, lying down, sleeping on a park bench, lying unconscious in the gutter, begging, singing, etc.—will therefore be handled under the civil provisions of this Act and not under the criminal law. See *District of Columbia* v. *Greenwell*, 96 Daily Wash. L. Reptr. 2133 (D.C. Ct. Gen. Sess. December 31, 1968).

SECTION 2. [*Definitions.*] For purposes of this Act:

(1) "alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in section 9(a) and approved under section 9(c);

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the division or providing treatment under this Act through a contract with the division under section 8(g) and meeting the standards prescribed in section 9(a) and approved under section 9(c);

(4) "commissioner" means the commissioner [or] of the department;

(5) "department" means [the State department of health or mental health];

(6) "director" means the director of the division of alcoholism;

(7) "division" means the division of alcoholism within the department established under section 3;

(8) "emergency service patrol" means a patrol established under section 17;

(9) "incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment;

(10) "incompetent person" means a person who has been adjudged incompetent by [the appropriate State court];

(11) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, which may be extended to alcoholics and intoxicated persons.

COMMENT

The term "alcoholic" is defined in two alternative ways for two different purposes. The first alternative is a relatively narrow definition based on lack of self-control regarding the use of alcoholic beverages. Lack of self-control may be manifested either by the inability to abstain from drinking for any significant time period, or by the ability to remain sober between drinking episodes but an inability to refrain from drinking to intoxication whenever drinking an alcoholic beverage. This relatively narrow definition has been the basis for the court decisions holding an alcoholic not criminally responsible for his intoxication.

The second alternative definition adopts the World Health Organization's broad approach that alcoholism can be defined as the use of alcoholic beverages to the extent that health or economic or social functioning are substantially impaired. The purpose of this broad definition is to make as large a group as possible eligible for treatment for alcoholism and related problems. Encouraging early treatment for drinking problems will ultimately lead to prevention. This broad definition of alcoholism is useful in making voluntary treatment available to as large a group as possible, but would be wholly inappropriate to define those alcoholics who justify civil commitment for involuntary treatment.

The Act defines "treatment" broadly to include a wide range of types and kinds of services to reflect the fact that there is no single or uniform method of treatment that will be effective for all alcoholics. The Act provides a flexible approach with a variety of kinds of medical, social, rehabilitative, and psychological services according to the individual's particular needs.

SECTION 3. [*Division of Alcoholism.*] A division of alcoholism is established within the department. The division shall be headed by a director appointed by the commissioner. The director shall be a qualified professional who has training and experience in handling medical-social problems or the organization or administration of treatment services for persons suffering from medical-social problems.

SECTION 4. [*Powers of Division.*] The division may:

(1) plan, establish, and maintain treatment programs as necessary or desirable;

(2) make contracts necessary or incidental to the performance of its duties and the execution of its powers, including contracts with public and private agencies, organizations, and individuals to pay them for services rendered or furnished to alcoholics or intoxicated persons;

(3) solicit and accept for use any gift of money or property made by will or otherwise, and any grant of money, services, or property from the Federal government, the State, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the Federal government or any of its agencies in making an application for any grant;

(4) administer or supervise the administration of the provisions relating to alcoholics and intoxicated persons of any State plan submitted for Federal funding pursuant to Federal health, welfare, or treatment legislation;

(5) coordinate its activities and cooperate with alcoholism programs in this and other States, and make contracts and other joint or cooperative arrangements with State, local, or private agencies in this and other States for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(6) keep records and engage in research and the gathering of relevant statistics; and

(7) do other acts and things necessary or convenient to execute the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest therein, and construct, lease, or otherwise provide treatment facilities for alcoholics and intoxicated persons.

SECTION 5. [*Duties of Division.*] The division shall:

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the [department of correction and board of parole] in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the [department of education], [boards of education], schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearing house for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the Governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the State's comprehensive health plan;

(11) review all State health, welfare, and treatment plans to be submitted for Federal funding under Federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of State and local governments and businesses and industries in the State;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(14) cooperate with [the commissioner of public safety] [highway commission] in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while [intoxicated];

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the Governor an annual report covering the activities of the division.

COMMENT

Section 5(9) gives the division the responsibility of specifying uniform methods for keeping statistical information, and collecting and disseminating such information. Confidentiality of individual patiet records will be protected in accordance with Section 15.

Sections 5 (10) and (11) authorize the division to advise the Governor with respect to the inclusion of alcoholism and intoxication under the State comprehensive health plan, and under all other State health, welfare, and treatment plans submitted for Federal funding. Under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91–616), each State must prepare a comprehensive alcoholism plan for Federal funding. The Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89–749) and the Partnership for Health Amendments of 1967 (Public Law 90–174) have also been amended by the 1970 Act to require that comprehensive State health plans must "provide for services for the prevention and treatment of alcohol abuse and alcoholism, commensurate with the extent of the problem" in order to receive Federal funds. Finally, numerous other relevant State plans, such as for vocational rehabilitation, are submitted for Federal funding. It will be the responsibility of the division to be certain that alcoholism and intoxication are included in all such pertinent State plans.

Section 5(15) gives the division the responsibility of encouraging general hospitals and other appropriate health facilities to admit and provide adequate treatment to alcoholics and intoxicated persons. This provision is particularly important because the 1970 Federal Act includes a provision under which a general hospital can be denied Federal funds under this law for discriminating against alcoholics.

Section 5(16) gives the division the responsibility of encouraging all health and disability insurance programs to include alcoholism as a covered illness. This provision applies to both private and governmental programs.

SECTION 6. [*Interdepartmental Coordinating Committee.*]

(a) An interdepartmental coordinating committee is established, composed of the [commissioners of public health, mental health, education, public welfare, correction, highway, public safety, vocational rehabilitation, and other appropriate agencies] and the director. The committee shall meet at least twice annually at the call of the commissioner, who shall be its chairman. The committee shall provide for the coordination of, and exchange of information on, all programs relating to alcoholism, and shall act as a permanent liaison among the departments engaged in activities affecting alcoholics and intoxicated persons. The committee shall assist the commissioner and director in formulating a comprehensive plan for prevention of alcoholism and for treatment of alcoholics and intoxicated persons.

(b) In exercising its coordinating functions, the committee shall assure that:

(1) the appropriate State agencies provide all necessary medical, social, treatment, and educational services for alcoholics and intoxicated persons and for the prevention of alcoholism, without unnecessary duplication of services;

(2) the several State agencies cooperate in the use of facilities and in the treatment of alcoholics and intoxicated persons; and

(3) all State agencies adopt approaches to the prevention of alcoholism and the treatment of alcoholics and intoxicated persons consistent with the policy of this act.

SECTION 7. [*Citizens Advisory Council on Alcoholism.*]

(a) The Governor shall appoint a citizens advisory council on alcoholism, composed of [15] members. The members shall serve for overlapping terms of 3 years each; one third of the members first appointed [, as nearly as may be practicable,] shall be appointed for one-, two-, and three-year terms respectively. Members shall have professional, research, or personal interest in alcoholism problems. The council shall meet at least once every [3] months and report on its activities and make recommendations to the director at least once a year.

(b) The council shall advise the director on broad policies, goals, and operation of the alcoholism program and on other matters the director refers to it, and shall encourage public understanding and support of the alcoholism program.

(c) Members of the council shall serve without compensation but shall receive reimbursement for travel and other necessary expenses actually incurred in the performance of their duties.

COMMENT

The qualifications of the members are defined broadly. It is expected that the Governor would appoint to the council individuals representing a broad range of background and experience, including representatives of citizens groups, voluntary organizations, professional groups, and recovered alcoholics.

SECTION 8. [*Comprehensive Program for Treatment; Regional Facilities.*]

(a) The division shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. [Subject to the approval of the commissioner, the director shall divide the State

into appropriate regions for the conduct of the program and establish standards for the development of the program on the regional level. In establishing the regions, consideration shall be given to city, town, and county lines and population concentrations.]

(b) The program of the division shall include:

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and followup treatment.

(c) The division shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 11 to 14. Treatment may not be provided at a correctional institution except for inmates.

(d) The division shall maintain, supervise, and control all facilities operated by it subject to policies of the department. The administrator of each facility shall make an annual report of its activities to the director in the form and manner the director specifies.

(e) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(f) The director shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities.

(g) The division may contract for the use of any facility as an approved public treatment facility if the director, subject to the policies of the department, considers this to be an effective and economical course to follow.

COMMENT

Whether or not the director divides the State into regional units for purposes of administration, it is desirable that all treatment services be community based. Alcoholics and other ill persons are treated more effectively through treatment services in their own communities, located conveniently to population centers so as to be quickly and easily accessible to patients and their families, rather than in large institutional settings.

The Act uses the concept of emergency treatment rather than the more popular phrase "detoxification center" as the latter concept tends to stigmatize alcoholics and set them apart from people with other illnesses or problems. These emergency services should be available 24 hours a day and readily accessible to those who need this assistance. In addition to medical services, emergency social services and appropriate diagnostic and referral services should be included.

"Inpatient treatment" refers to full-time residential treatment in an institution. Although alcoholics and intoxicated persons ordinarily do not require full-time inpatient treatment services, such care must be available for those who do need it. Since long-term inpatient services are inappropriate for alcoholics, inpatient treatment should be designed to facilitate the patient's return to his family and the community or to other appropriate care services as rapidly as possible.

"Intermediate treatment" refers to residential treatment that is less than full time and that can be provided in a variety of community facilities, such as halfway houses, day or night hospitals, or foster homes.

"Outpatient and followup treatment" includes the same wide range of treatment services and modalities offered in inpatient or intermediate service settings, but in outpatient treatment, the client is not a full or part-time resident of the treatment facility. Such services may be offered in a wide variety of settings in the community, such as clinics and social centers and even in the patient's own home.

Section 8(a) requires that all existing appropriate private and public resources be coordinated with and used whenever possible. For example, general hospitals may be used for emergency care services, and community mental health centers may be utilized for a variety of kinds of services for alcoholics. The creation of a new and separate network of treatment facilities for alcoholics would not be desirable, practical, or effective.

Section 8(c) requires the department to provide adequate and appropriate treatment for all alcoholics and intoxicated persons, including both the vast majority of persons who will come to these facilities voluntarily and the small minority who may be involuntarily committed, in accordance with the provisions of sections 13 and 14 of the Act.

SECTION 9. [*Standards for Public and Private Treatment Facilities; Enforcement Procedures; Penalties.*]

(a) The division shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged by the division for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

(b) The division periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The division shall maintain a list of approved public and private treatment facilities.

(d) Each approved public and private treatment facility shall file with the division on request, data, statistics, schedules, and information the division reasonably requires. An approved public or private treatment facility that without good cause fails to furnish

any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

(e) The division, after holding a hearing, may suspend, revoke, limit, or restrict an approval, or refuse to grant an approval, for failure to meet its standards.

(f) The [district] court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

(g) Upon petition of the division and after a hearing held upon reasonable notice to the facility, the [district] court may issue a warrant to an officer or employee of the division authorizing him to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the division or which the division has reasonable cause to believe is operating in violation of this Act.

SECTION 10. [*Acceptance for Treatment; Rules.*] The director shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In establishing the rules the director shall be guided by the following standards:

(1) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(2) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

(3) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(4) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(5) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

COMMENT

Section 10(1) expresses the Act's clear preference for voluntary over involuntary treatment. Voluntary treatment is more desirable from both a medical and legal point of view. Experience has shown that the vast majority of alcoholics are quite willing to accept adequate and appropriate treatment. Section 14 of the Act makes it clear that involuntary treatment is permitted only in exceptional and very clearly prescribed circumstances.

Section 10(2) is based on the fact that most alcoholics do not need long term inpatient care, but can be more successfully treated in outpatient or intermediate care settings (such as halfway houses). This section covers both voluntary and involuntary treatment, for section 14(h) allows the division to transfer a committed patient from a more restrictive to a less restrictive treatment modality whenever such transfer is "medically advisable."

Section 10(3) recognizes that alcoholics, like persons with other chronic illnesses, may relapse. Such relapses are to be expected as part of the illness and the individual should not be penalized. Prior treatment and withdrawal from treatment, even if repeated, should not bar a person from subsequent participation in a treatment program. It was deemed desirable to include this specific provision in the Act in view of the more punitive provisions against readmission in many older laws.

Section 10(4) provides that an individualized treatment plan must be prepared and maintained for each patient on a current basis. Such an individualized plan would include the factual record of all treatment provided and must be specifically tailored to meet the needs of each patient. A "boiler plate" treatment form for all patients would *not* meet the requirements of this section. This provision will ensure that patients are receiving treatment in accordance with their specific needs, and is crucial in the case of civilly committed patients in order to guard against the possibility of commitment without appropriate treatment.

Section 10(5) reinforces the Act's strong emphasis on the need for a continuum of coordinated treatment services (see also section 1 and section 8(a)) and requires the division to ensure that when a person leaves a form of treatment, other appropriate treatment services will be available to him.

SECTION 11. [*Voluntary Treatment of Alcoholics.*] (a) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian, or other legal representative may make the application.

(b) Subject to rules adopted by the director, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to rules adopted by the director, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(c) If a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the division shall arrange for

assistance in obtaining supportive services and residential facilities.

(d) If a patient leaves an approved public treatment facility, with or against the advice of the administrator in charge of the facility, the division shall make reasonable provisions for his transportation to another facility or to his home. If he has no home he shall be assisted in obtaining shelter. If he is a minor or an incompetent person the request for discharge from an inpatient facility shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he was the original applicant.

COMMENT

Most patients treated under this Act will voluntarily seek treatment. The provisions of this section allow the patient to seek treatment in the same manner as he would for any other health problem or illness. The Act encourages voluntary treatment by not requiring the patient to agree to voluntarily commit himself for a specified length of time or to accept any of the other restrictions that apply to involuntarily committed patients. Section 11 does not require either a predetermined minimum voluntary stay or a specified number of days of notice prior to seeking discharge. Such provisions would discourage treatment and would subject patients to restrictions that do not apply to patients with other medical problems.

Section 11 also requires the division to provide coordinated services (see also sections 1, 8(a), and 10(e)) and to assist the patient in getting from one service to another, including the arranging of transportation if necessary. Section 11(d) expressly provides that the division must make such provision even if the patient leaves the treatment facility against medical advice.

SECTION 12. [*Treatment and Services for Intoxicated Persons and Persons Incapacitated by Alcohol.*]

(a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility, or other health facility by the police or the emergency service patrol.

(b) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment. [If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons.] The police or the emergency service patrol, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

(c) A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

(d) A person who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility (1) once he is no longer incapacitated by alcohol, or (2) if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under section 13. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

(g) The police or members of the emergency service patrol who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable therefor.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

COMMENT

A small minority of intoxicated persons are incapacitated in that they are unconscious or incoherent or similarly so impaired in judgment that they cannot make a rational decision with regard to their need for treatment. Section 12(b) authorizes the police or emergency service patrol to take such individuals into protective custody and to a public treatment facility for emergency care. This is intended to assure that those most seriously in need of care will get it.

Protective custody under (b) is similar to the way in which the police provide emergency assistance to other ill people, such as those in accidents or those who have sudden heart attacks. It is a civil procedure, and no arrest record or record which implies a criminal charge is to be made. Since the police officer may sometimes have to decide whether a man who refuses help appears to be incapacitated by alcohol or because of some other reason, section 12(g) protects the policeman should his conclusion, made in good faith, be incorrect. It provides that he cannot be held criminally or civilly liable for false arrest or imprisonment as long as he is acting in compliance with this section. Willful malice or abuse, however, would not be considered to be in compliance with this section of the Act.

Section 12(d) provides that an incapacitated person can be held at a treatment facility without consent or further civil procedures for not longer than 48 hours. By the end of 48 hours, most persons who have been incapacitated by alcohol will be sufficiently detoxified to be able to make a rational decision about their need for further treatment. To provide for those very few individuals who may still be incapacitated (perhaps even unconscious) at the end of 48 hours, section 13 provides for an emergency commitment procedure based on a written application and a certificate from a physician who is not employed by the division.

Other provisions of section 12 provide that the individual in a public treatment facility must be examined by a licensed physician as soon as possible. This is to ensure, in accordance with section 8(b), that these facilities will provide the necessary medical services.

SECTION 13. [*Emergency Commitment.*]

(a) An intoxicated person who (1) has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or (2) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within 2 days before the certificate's date and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the division is not eligible to be the certifying physician.

(c) Upon approval of the application by the administrator in charge of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection (e).

(d) The administrator in charge of an approved public treatment facility shall refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than [5] days. If a petition for involuntary commitment under section 14 has been filed within the [5] days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult counsel.

COMMENT

The test contained in the definition of "incapacitated by alcohol" is whether the person's judgment is so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment. Section 13(a)(2) may, therefore, cover the alcoholic who threatens suicide. If he falls within the definition, he would be subject to commitment for emergency treatment.

It is anticipated that the need to resort to short term commitment for emergency medical care under this section will arise most infrequently, but the procedure does provide a means of dealing with situations not covered by other parts of the Act. It is meant to be utilized only in true emergency situations where immediate action to cope with the crisis is essential and where the delay of court proceedings would be dangerous. For example, it might be necessary to use this emergency commitment procedure for an alcoholic who becomes intoxicated at home and whose behavior becomes assaultive, or for an in-

capacitated alcoholic already detained involuntarily in a treatment facility for the 48-hour maximum who continues to be so severely incapacitated, perhaps because of brain damage, that he cannot make a rational decision about his continuing need for care.

SECTION 14. [*Involuntary Commitment of Alcoholics.*]

(a) A person may be committed to the custody of the division by the [district] court upon the petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he (1) has threatened, attempted, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within [2] days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the division is not eligible to be the certifying physician.

(b) Upon filing the petition, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian if he is a minor, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(c) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall be present unless the court believes that his presence is likely to be injurious to him; in this event the court shall appoint a guardian *ad litem* to represent him throughout the proceeding. The court shall examine the person in open court, or if advisable, shall examine the person out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to be examined by a court-appointed licensed physician. If he refuses and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the division for a period of not more than [5] days for purposes of a diagnostic examination.

(d) If after hearing all relevant evidence, including the results of any diagnostic examination by the division, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, it shall make an order of commitment to the division. It may not order commitment of a person unless it determines that the division is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

(e) A person committed under this section shall remain in the custody of the division for treatment for a period of [30] days unless sooner discharged. At the end of the [30] day period, he shall be discharged automatically unless the division before expiration of the period obtains a court order for his recommitment upon the grounds set forth in subsection (a) for a further period of [90] days unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the division shall apply for recommitment if after examination it is determined that the likelihood still exists.

(f) A person recommitted under subsection (e) who has not been discharged by the division before the end of the [90] day period shall be discharged at the expiration of that period unless the division, before expiration of the period, obtains a court order on the grounds set forth in subsection (a) for recommitment for a further period not to exceed [90] days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the division shall apply for recommitment if after examination it is determined that the likelihood still exists. Only 2 recommitment orders under subsections (e) and (f) are permitted.

(g) Upon the filing of a petition for recommitment under subsections (e) or (f), the court shall fix a date for hearing no later than [10] days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection (a) if different from the petitioner for recommitment, one of his parents or his legal guardian if he is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (c).

(h) The division shall provide for adequate and appropriate treatment of a person committed to its custody. The division may transfer any person com-

mitted to its custody from one approved public treatment facility to another if transfer is medically advisable.

(i) A person committed to the custody of the division for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(1) In case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer an alcoholic or the likelihood no longer exists; or

(2) In case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer adequate or appropriate.

(j) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of any proceedings relating to his commitment and recommitment, and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(k) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

(l) A person committed under this Act may at any time seek to be discharged from commitment by writ of habeas corpus.

[(m) The venue for proceedings under this section is the place in which the person to be committed resides or is present.]

COMMENT

The Act specifically states that a refusal to undergo treatment does not by itself constitute evidence of lack of judgment with respect to the need for treatment. Thus, involuntary commitment would *not* be warranted merely because the person needs treatment, or has substantially inconvenienced his family, or has frequently been intoxicated in public, or because his drinking is harmful to his health. Commitment would be warranted, however, if the alcoholic exhibited cognitive deficiencies and was so debilitated that his thinking was confused not only with respect to his drinking problem but in other areas of behavior as well.

Section 14(d) prohibits mere custodial care by providing that a person may not be committed unless the division is able to provide "adequate and appropriate treatment for him and the treatment is likely to be beneficial."

The burden of proof in each recommitment is on the petitioner since each is an independent action.

If it is necessary to hold an individual beyond the maximum period, other provisions of State law must be used.

SECTION 15. [*Records of Alcoholics and Intoxicated Persons.*]

(a) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(b) Notwithstanding subsection (a), the director may make available information from patients' records for purposes of research into the causes and treatment of alcoholism. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

COMMENT

The treatment of privileged information in the courts and disclosure with the consent of the patient are matters of general State law. This section does, however, provide for the use of treatment records for research purposes so long as patients' names and other identifying information are not disclosed.

SECTION 16. [*Visitation and Communication of Patients.*]

(a) Subject to reasonable rules regarding hours of visitation which the director may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel, and for continuing contact with family and friends consistent with an effective treatment program.

(b) Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. The director may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

SECTION 17. [*Emergency Service Patrol; Establishment; Rules.*]

(a) The division and [counties, cities and other municipalities] may establish emergency service patrols. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall transport intoxicated persons to their homes and to and from public treatment facilities.

(b) The director shall adopt rules for the establishment, training, and conduct of emergency service patrols.

COMMENT

The experience of using civilians and plainclothes policemen, has demonstrated the effectiveness of this method. In some communities, for example, existing rescue squads that supply help and transportation in other medical emergencies might be used to assist intoxicated and incapacitated individuals. This provision does not require the establishment of an emergency service patrol, but authorizes such a patrol, should it meet the needs of a particular community.

SECTION 18. [*Payment for Treatment; Financial Ability of Patients.*]

[(a) If treatment is provided by an approved public treatment facility and the patient has not paid the charge therefor, the division is entitled to (1) any payment received by the patient or to which he may be entitled because of the services rendered, and (2) from any public or private source available to the division because of the treatment provided to the patient.]

[(b) A patient in an approved treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability, is liable to the division for cost of maintenance and treatment of the patient therein in accordance with rates established.]

[(c) The director shall adopt rules governing financial ability that take into consideration the income, savings and other personal and real property of the person required to pay, and any support being furnished by him to any person he is required by law to support.]

SECTION 19. [*Criminal Laws Limitations.*]

(a) No county, municipality, or other political subdivision may adopt or enforce a local law, ordinance, resolution, or rule having the force of law that includes drinking, being a common drunkard, or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction.

(b) No county, municipality, or other political subdivision may interpret or apply any law of general application to circumvent the provision of subsection (a).

(c) Nothing in this Act affects any law, ordinance, resolution, or rule against drunken driving, driving under the influence of alcohol, or other similar offense involving the operation of a vehicle, aircraft, boat, machinery, or other equipment, or regarding the sale, purchase, dispensing, possessing, or use of alcoholic beverages at stated times and places or by a particular class of persons.

COMMENT

An important corollary to section 19 is section 37, which provides for the repeal of the State laws that are inconsistent with this Act. Under section 37, therefore, States would be expected to repeal all the relevant portions of their criminal statutes under which drunkenness is the gravamen of the offense with the exception of (c).

SECTION 20. [*Severability.*] If any provision of this Act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

[SECTION 21. [*Application of Administrative Procedure Act.*] Except as otherwise provided in this Act, the State Administrative Procedure Act applies to and governs all administrative action taken by the director.]

[SECTION 22. [*Applicability and Scope.*] Sections 23 to 34 apply to the director and prescribe the procedures to be observed by him in exercising his powers under this Act]

[SECTION 23. [*Public Information; Adoption of Rules; Availability of Rules and Orders.*]

(a) In addition to other rule-making requirements imposed by law, the director shall:

(1) adopt as a rule a description of the organization of his office, stating the general course and method of the operations of his office and methods whereby the public may obtain information or make submissions or requests;

(2) adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available, including a description of all forms and instructions used by the director or his office;

(3) make available for public inspection all rules and all other written statements of policy or interpretations formulated, adopted, or used by the director in the discharge of his functions;

(4) make available for public inspection all final orders, decisions, and opinions.

(b) No rule, order, or decision of the director is effective against any person or party, nor may it be invoked by the director for any purpose, until it has been made available for public inspection as herein required. This provision is not applicable in favor of any person or party who has knowledge thereof.]

[SECTION 24. [*Procedure for Adoption of Rules.*]

(a) Prior to the adoption, amendment, or repeal of any rule, the director shall:

(1) give at least 20 days' notice of his intended action. The notice shall include a statement of either the terms or substance of the intended action or a description of the subjects and issues involved, and

the time when, the place where, and the manner in which interested persons may present their views thereon. The notice shall be mailed to all persons who have made timely request of the director for advance notice of his rule-making proceedings and shall be published in [here insert the medium of publication appropriate for the adopting State];

(2) afford all interested persons reasonable opportunity to submit data, views, or arguments, orally or in writing. In case of substantive rules, opportunity for oral hearing must be granted if requested by 25 persons, by a governmental subdivision or agency, or by an association having not less than 25 members. The director shall consider fully all written and oral submissions respecting the proposed rule. Upon adoption of a rule the director, if requested to do so by an interested person either prior to adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, incorporating therein his reasons for overruling the considerations urged against its adoption.

(b) No rule is valid unless adopted in substantial compliance with this section. A proceeding to contest any rule on the ground of noncompliance with the procedural requirements of this section must be commenced within 2 years from the effective date of the rule.]

[SECTION 25. [*Filing and Taking Effect of Rules.*]

(a) The director shall file in the office of the [Secretary of State] a certified copy of each rule adopted by him. The [Secretary of State] shall keep a permanent register of the rules open to public inspection.

(b) Each rule hereafter adopted is effective 20 days after filing, except that, if a later date is specified in the rule, the later date is the effective date.]

[SECTION 26. [*Publication of Rules.*]

(a) The [Secretary of State] shall compile, index, and publish all effective rules adopted by the director. Compilations shall be supplemented or revised as often as necessary.

(b) Compilations shall be made available upon request to [agencies and officials of this State] free of charge and to other persons at prices fixed by the [Secretary of State] to cover mailing and publication costs.]

[SECTION 27. [*Petition for Adoption of Rules.*]

An interested person may petition the director requesting the adoption, amendment, or repeal of a rule. The director shall prescribe by rule the form for petitions and the procedure for their submission, consideration, and disposition. Within 30 days after submission of a petition, the director either shall deny the petition in writing (stating his reasons for the denial) or shall initiate rule-making proceedings in accordance with the provisions on procedure for adoption of rules (section 24).]

[SECTION 28. [*Declaratory Judgment on Validity or Applicability of Rules.*]

The validity or applicability of a rule may be determined in an action for declaratory judgment in the [. . . court] if it is alleged that the rule, or its threatened application, interferes with or impairs, or threatens to interfere with or impair, the legal rights or privileges of the plaintiff. The director shall be made a party to the action. A declaratory judgment may be rendered whether or not the plaintiff has requested the director to pass upon the validity or applicability of the rule in question.]

[SECTION 29. [*Declaratory Rulings by Director.*]

The director shall provide by rule for the filing and prompt disposition of petitions of declaratory rulings as to the applicability of any statutory provision or of any rule of the director. Rulings disposing of petitions have the same status as decisions or orders in contested cases.]

[SECTION 30. [*Contested Cases; Notice; Hearing; Records.*]

(a) In a contested case, all parties shall be afforded an opportunity for hearing after reasonable notice.

(b) The notice shall include:

(1) a statement of the time, place, and nature of the hearing;

(2) a statement of the legal authority and jurisdiction under which the hearing is to be held;

(3) a reference to the particular provisions of the statutes and rules involved;

(4) a short and plain statement of the matters asserted. If the director or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter upon application a more definite and detailed statement shall be furnished.

(c) Opportunity shall be afforded all parties to respond and present evidence and argument on all issues involved.

(d) Unless precluded by law, informal disposition may be made of any contested case by stipulation, agreed settlement, consent order, or default.

(e) The record in a contested case shall include:

(1) all pleadings, motions, intermediate rulings;

(2) evidence received or considered;

(3) a statement of matters officially noticed;

(4) questions and offers of proof, objections, and rulings thereon;

(5) proposed findings and exceptions;

(6) any decision, opinion, or report by the officer presiding at the hearing;

(7) all staff memoranda or data submitted to the hearing officer or members of the office of the administrator in connection with their consideration of the case.

(f) Oral proceedings or any part thereof shall be transcribed on request of any party [, but at his expense].

(g) Findings of fact shall be based exclusively on the evidence and on matters officially noticed.]

[SECTION 31. [*Rules of Evidence; Official Notice.*] In contested cases:

(1) irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The rules of evidence as applied in [non-jury] civil cases in the [. . . court of this State] shall be followed. When necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not admissible thereunder may be admitted (except where precluded by statute) if it is of a type commonly relied upon by reasonably prudent men in the conduct of their affairs. The director shall give effect to the rules of privilege recognized by law. Objections to evidentiary offers may be made and shall be noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form;

(2) documentary evidence may be received in the form of copies or excerpts, if the original is not readily available. Upon request, parties shall be given an opportunity to compare the copy with the original;

(3) a party may conduct cross-examinations required for a full and true disclosure of the facts;

(4) notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the director's specialized knowledge. Parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material notices, including any staff memoranda or data, and they shall be afforded an opportunity to contest the material so noticed. The director's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence.]

[SECTION 32. [*Decisions and Orders.*]

A final decision or order adverse to a party in a contested case shall be in writing or stated in the record. A final decision shall include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. If, in accordance with rules of the director, a party submitted proposed findings of fact, the decision shall include a ruling upon each proposed finding. Parties shall be notified either personally or by mail of any decision or order. Upon request a copy of the decision or order shall be delivered or mailed forthwith to each party and to his attorney of record.]

[SECTION 33. [*Judicial Review of Contested Cases.*]

(a) A person who has exhausted all administrative remedies available before the director and who is aggrieved by a final decision in a contested case is entitled to judicial review under this part. This section does not limit utilization of or the scope of judicial review available under other means of review, redress, relief, or trial *de novo* provided by law. A preliminary, procedural, or intermediate action or ruling of the director is immediately reviewable if review of the final decision of the director would not provide an adequate remedy.

(b) Proceedings for review are instituted by filing a petition in the [. . . court] within [30] days after [mailing notice of] the final decision of the director or, if a rehearing is requested within [30] days after the decision thereon. Copies of the petition shall be served upon the director and all parties of record.

(c) The filing of the petition does not itself stay enforcement of the decision of the director. The director may grant, or the reviewing court may order, a stay upon appropriate terms.

(d) Within [30] days after the service of the petition, or within further time allowed by the court, the director shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review. By stipulation of all parties to the review proceedings, the record may be shortened. A party unreasonably refusing to stipulate to limit the record may be taxed by the court for the additional costs. The court may require or permit subsequent corrections or additions to the record.

(e) If, before the date set for hearing, application is made to the court for leave to present additional evidence, and it is shown to the satisfaction of the court that the additional evidence is material and that there were good reasons for failure to present it in the proceeding before the director, the court may order that the additional evidence be taken before the director upon conditions determined by court. The director may modify his findings and decision by reason of the additional evidence and any modifications, new findings, or decisions with the reviewing court.

(f) The review shall be conducted by the court without a jury and shall be confined to the record. In cases of alleged irregularities in procedure before the director, not shown in the record, proof thereon may be taken in the court. The court, upon request, shall hear oral argument and receive written briefs.

(g) The court shall not substitute its judgment for that of the director as to the weight of the evidence on questions of fact. The court may affirm the decision of the director or remand the case for further

proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(1) in violation of constitutional or statutory provisions;

(2) in excess of the statutory authority of the director;

(3) made upon unlawful procedure;

(4) affected by other error of law;

(5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

(6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.]

[SECTION 34. [*Appeals.*] An aggrieved party may obtain a review of any final judgment of the [. . . court] under this part by appeal to the [. . . court]. The appeal shall be taken as in other civil cases.]

SECTION 35. [*Short Title*] This Act may be cited as the Uniform Alcoholism and Intoxication Treatment Act.

SECTION 36. [*Application and Construction.*] This Act shall be so applied and construed as to effectuate its general purpose to make uniform the law with respect to the subject of this Act among those States which enact it.

SECTION 37. [*Repeal.*] The following Acts and parts of Acts are repealed:

(1)

(2)

(3)

SECTION 38. [*Effective Date.*] This Act shall become effective [90] days after its passage.

APPENDIX C

COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOL PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

PUBLIC LAW 91-616

Public Law 91-616
91st Congress, S. 3835
December 31, 1970

An Act

To provide a comprehensive Federal program for the prevention and treatment of alcohol abuse and alcoholism.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

SHORT TITLE

Section 1. This Act may be cited as the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970".

TITLE I—NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

ESTABLISHMENT OF THE INSTITUTE

Sec. 101. (a) There is established in the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism (hereafter in this Act referred to as the "Institute") to administer the programs and authorities assigned to the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the "Secretary") by this Act and part C of the Community Mental Health Centers Act. The Secretary, acting through the Institute, shall, in carrying out the purposes of section 301 of the Public Health Service Act with respect to alcohol abuse and alcoholism, develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics.

82 Stat. 1006; Ante, p. 59. 42 USC 2688e. 58 Stat. 691; 79 Stat. 448. 42 USC 241.

(b) The Institute shall be under the direction of a Director who shall be appointed by the Secretary.

REPORTS BY THE SECRETARY

Sec. 102. The Secretary shall—

(1) submit an annual report to Congress which shall include a description of the actions taken, services provided, and funds expended under this Act and part C of the Community Mental Health Centers Act, an evaluation of the effectiveness of such actions, services, and expenditures of funds, and such other information as the Secretary considers appropriate;

Reports to President and Congress.

(2) submit to Congress on or before the expiration of the one-year period beginning on the date of enactment of this Act a report (A) containing current information on the health consequences of using alcoholic beverages, and (B) containing such recommendations for legislation and administrative action as he may deem appropriate;

(3) submit such additional reports as may be requested by the President of the United States or by Congress; and

(4) submit to the President of the United States and to Congress such recommendations as will further the prevention, treatment, and control of alcohol abuse and alcoholism.

TITLE II—ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION PROGRAMS FOR FEDERAL CIVILIAN EMPLOYEES

ALCOHOL ABUSE AND ALCOHOLISM AMONG FEDERAL CIVILIAN EMPLOYEES

Sec. 201. (a) The Civil Service Commission shall be responsible for developing and maintaining, in cooperation with the Secretary and with other Federal agencies and departments, appropriate prevention, treatment, and rehabilitation programs and services for alcohol abuse and alcoholism among Federal civilian employees, consistent with the purposes of this Act. Such policies and services shall make optimal use of existing governmental facilities, services, and skills.

(b) The Secretary, acting through the Institute, shall be responsible for fostering similar alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs and services in State and local governments and in private industry.

(c) (1) No person may be denied or deprived of Federal civilian employment or a Federal professional or other license or right solely on the ground of prior alcohol abuse or prior alcoholism.

(2) This subsection shall not apply to employment (A) in the Central Intelligence Agency, the Federal Bureau of Investigation, the National Security Agency, or any other department or agency of the Federal Government designated for purposes of national

security by the President, or (B) in any position in any department or agency of the Federal Government, not referred to in clause (A), which position is determined pursuant to regulations prescribed by the head of such agency or department to be a sensitive position.

(d) This title shall not be construed to prohibit the dismissal from employment of a Federal civilian employee who cannot properly function in his employment.

TITLE III—FEDERAL ASSISTANCE FOR STATE AND LOCAL PROGRAMS

PART A—FORMULA GRANTS

AUTHORIZATION

Appropriation.

Sec. 301. There are authorized to be appropriated $40,000,000 for the fiscal year ending June 30, 1971, $60,000,000 for the fiscal year ending June 30, 1972, $80,000,000 for the fiscal year ending June 30, 1973, for grants to States to assist them in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. For purposes of this part, the term "State" includes the District of Columbia, the Virgin Islands, the Commonwealth of Puerto Rico, Guam, American Samoa, and the Trust Territory of the Pacific Islands, in addition to the fifty States.

"State."

STATE ALLOTMENT

Sec. 302. (a) For each fiscal year the Secretary shall, in accordance with regulations, allot the sums appropriated for such year pursuant to section 301 among the States on the basis of the relative population, financial need, and need for more effective prevention, treatment, and rehabilitation of alcohol abuse and alcoholism; except that no such allotment to any State (other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands) for any fiscal year shall be less than $200,000.

(b) Any amount so allotted to a State (other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the

Pacific Islands) and remaining unobligated at the end of such year shall remain available to such State, for the purposes for which made, for the next fiscal year (and for such year only), and any such amount shall be in addition to the amounts allotted to such State for such purpose for such next fiscal year; except that any such amount, remaining unobligated at the end of the sixth month following the end of such year for which it was allotted, which the Secretary determines will remain unobligated by the close of such next fiscal year, may be reallotted by the Secretary, to be available for the purposes for which made until the close of such next fiscal year, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this part, and any amount so reallotted to a State shall be in addition to the amounts allotted and available to the States for the same period. Any amount allotted under subsection (a) to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands for a fiscal year and remaining unobligated at the end of such year shall remain available to it, for the purposes for which made, for the next two fiscal years (and for such years only), and any such amount shall be in addition to the amounts allotted to it for such purpose for each of such next two fiscal years; except that any such amount, remaining unobligated at the end of the first of such next two years, which the Secretary determines will remain unobligated at the close of the second of such next two years, to any other of such four States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this part, and any amount so reallotted to a State shall be in addition to the amounts allotted and available to the State for the same period.

(c) At the request of any State, a portion of any allotment or allotments of such State under this part shall be available to pay that portion of the expenditures found necessary by the Secretary for the proper and efficient administration during such year of the State plan approved under this part, except that not more than 10 per centum of the total of the allotments of such State for a year, or $50,000, whichever is the least, shall be available for such purpose for such year.

STATE PLANS

Sec. 303. (a) Any State desiring to participate in this part shall submit a State plan for carrying out its purposes. Such plan must—

(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) (hereafter in this section referred to as the "State agency") will have authority to carry out such plan in conformity with this part;

(3) provide for the designation of a State advisory council which shall include representatives of nongovernmental organizations or groups, and of public agencies concerned with the prevention and treatment of alcohol abuse and alcoholism, to consult with the State agency in carrying out the plan;

(4) set forth, in accordance with criteria established by the Secretary, a survey of need for the prevention and treatment of alcohol abuse and alcoholism including a survey of the health facilities needed to provide services for alcohol abuse and alcoholism and a plan for the development and distribution of such facilities and programs throughout the State;

(5) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports;

(7) provide that the Comptroller General of the United

States or his duly authorized representatives shall have access for the purpose of audit and examination to the records specified in paragraph (6);

(8) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary;

(9) provide reasonable assurance that Federal funds made available under this part for any period will be so used as to supplement and increase, to the extent feasible and practical, the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the programs described in this part, and will in no event supplant such State, local, and other non-Federal funds; and

(10) contain such additional information and assurance as the Secretary may find necessary to carry out the provisions and purposes of this part.

State plans, approval.

(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection

PART B—PROJECT GRANTS AND CONTRACTS

GRANTS AND CONTRACTS FOR THE PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM

80 Stat. 1009; Ante, p. 59. 42 USC 2688e note.

Sec. 311. Section 247 of part C of the Community Mental Health Centers Act is amended to read as follows:

"GRANTS AND CONTRACTS FOR THE PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM

"Sec. 247. (a) The Secretary, acting through the National Institute on Alcohol Abuse and Alcoholism, may make grants to public and private nonprofit agencies, organizations, and institutions and may enter into contracts with public and private agencies, organizations, and institutions, and individuals—

"(1) to conduct demonstration, service, and evaluation projects,

"(2) to provide education and training,

"(3) to provide programs and services in cooperation with schools, courts, penal institutions, and other public agencies, and

"(4) to provide counseling and education activities on an

individual or community basis, for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics.

"(b) Projects for which grants or contracts are made under this section shall, whenever possible, be community based, provide a comprehensive range of services, and be integrated with, and involve the active participation of, a wide range of public and nongovernmental agencies, organizations, institutions, and individuals.

"(c) (1) In administering the provisions of this section, the Secretary shall require coordination of all applications for programs in a State. Applications.

"(2) Each applicant from within a State, upon filing its application with the Secretary for a grant or contract under this section, shall submit a copy of its application for review by the State agency designated under section 303 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, if such agency exists. Such State agency shall be given not more than thirty days from the date of receipt of the application to submit to the Secretary, in writing, an evaluation of the project set forth in the application. Such evaluation shall include comments on the relationship of the project to other projects pending and approved and to the State comprehensive plan for treatment and prevention of alcohol abuse and alcoholism under such section 303. The State shall furnish the applicant a copy of any such evaluation. Filing. Ante, p. 1850.

"(3) Approval of any application for a grant or contract by the Secretary, including the earmarking of financial assistance for a program or project, may be granted only if the application substantially meets a set of criteria established by the Secretary that— Approval, criteria.

"(A) provide that the activities and services for which assistance under this section is sought will be substantially administered by or under the supervision of the applicant;

"(B) provide for such methods of administration as are necessary for the proper and efficient operation of such programs or projects;

"(C) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement

of and accounting for Federal funds paid to the applicant; and

"(D) provide reasonable assurance that Federal funds made available under this section for any period will be so used as to supplement and increase, to the extent feasible and practical, the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the programs described in this section, and will in no event supplant such State, local, and other non-Federal funds.

Appropriation.

"(d) To carry out the purposes of this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971, $40,000,000 for the fiscal year ending June 30, 1972, and $50,000,000 for the fiscal year ending June 30, 1973."

PART C—ADMISSION TO HOSPITALS

ADMISSION OF ALCOHOL ABUSERS AND ALCOHOLICS TO PRIVATE AND PUBLIC HOSPITALS

Failure to comply, termination of Federal assistance.

Sec. 321. (a) Alcohol abusers and alcoholics shall be admitted to and treated in private and public general hospitals, which receive Federal funds for alcoholic treatment programs, on the basis of medical need and shall not be discriminated against solely because of their alcoholism. No hospital that violates this section shall receive Federal financial assistance under the provisions of this Act; except that the Secretary shall not terminate any such Federal assistance until the Secretary has advised the appropriate person or persons of the failure to comply with this section, and has provided an opportunity for correction or a hearing.

Hearing opportunity. Judicial review.

77 Stat. 298. 42 USC 2694.

(b) Any action taken by the Secretary pursuant to this section shall be subject to such judicial review as is provided by section 404 of the Community Mental Health Centers Act.

PART D—GENERAL

COMPREHENSIVE STATE HEALTH PLANS

80 Stat. 1184; Ante, p. 1241. 42 USC 246.

Sec. 331. Section 314(d) (2) of the Public Health Service Act is amended—

(1) by striking out "and" at the end of subparagraph (J);

(2) by striking out the period at the end of subparagraph (K) and inserting in lieu thereof "; and"; and

(3) by adding after subparagraph (K) the following new subparagraph:

"(L) provide for services for the prevention and treatment of

alcohol abuse and alcoholism, commensurate with the extent of the problem."

SPECIALIZED FACILITIES

Sec. 332. Section 243(a) of the Community Mental Health Centers Act is amended (1) by inserting "or leasing" after "construction", and (2) by inserting "facilities for emergency medical services, intermediate care services, or outpatient services, and" immediately before "post-hospitalization treatment facilities". 82 Stat. 1008
42 USC 2688h.

CONFIDENTIALITY OF RECORDS

Sec. 333. The Secretary may authorize persons engaged in research on, or treatment with respect to, alcohol abuse and alcoholism to protect the privacy of individuals who are the subject of such research or treatment by withholding from all persons not connected with the conduct of such research or treatment the names or other identifying characteristics of such individuals. Persons so authorized to protect the privacy of such individuals may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding to indentify such individuals. Research and treatment populations.

TITLE IV—THE NATIONAL ADVISORY COUNCIL ON ALCOHOL ABUSE AND ALCOHOLISM

ESTABLISHMENT OF COUNCIL

Sec. 401. (a) Section 217(a) of the Public Health Service Act is amended— 64 Stat. 446.
42 USC 218.

(1) in the first sentence thereof, by inserting "the National Advisory Council on Alcohol Abuse and Alcoholism," immediately after "the National Advisory Mental Health Council,";

(2) in the second sentence thereof, by (A) inserting "the National Advisory Council on Alcoholic Abuse and Alcoholism," immediately after "the National Advisory Mental Health Council,", and (B) inserting "alcohol abuse and alcoholism," immediately after "psychiatric disorders,"; and

(3) in the fourth sentence, (A) by inserting "(other than the members of the National Advisory Council on Alcohol Abuse and Alcoholism)" after "the terms of the members"; (B) by striking out "and" before "(2)"; and (C) by striking out the period at the end and inserting a semicolon and "and (3) the

terms of the members of the National Council on Alcohol Abuse and Alcoholism first taking office after the date of enactment of this clause, shall expire as follows: Three shall expire four years after such date, three shall expire three years after such date, three shall expire two years after such date, and three shall expire one year after such date, as designated by the Secretary at the time of appointment."

64 Stat. 446. 42 USC 218.

(b) Section 217(b) of such Act is amended, in the second sentence thereof, by inserting "alcohol abuse and alcoholism," immediately after "mental health,".

(c) Section 217 of such Act is further amended by adding at the end thereof the following new subsection:

"(d) The National Advisory Council on Alcohol Abuse and Alcoholism shall advise, consult with, and make recommendations to, the Secretary on matters relating to the activities and functions of the Secretary in the field of alcohol abuse and alcoholism. The Council is authorized (1) to review research projects or programs submitted to or initiated by it in the field of alcohol abuse and alcoholism and recommend to the Secretary any such projects which it believes show promise of making valuable contributions to human knowledge with respect to the cause, prevention, or methods of diagnosis and treatment of alcohol abuse and alcoholism, and (2) to collect information as to studies being carried on in the field of alcohol abuse and alcoholism and, with the approval of the Secretary, make available such information through appropriate publications for the benefit of health and welfare agencies or organizations (public or private) or physicians or any other scientists, and for the information of the general public. The Council is also authorized to recommend to the Secretary, for acceptance pursuant to section 501 of this Act, conditional gifts for work in the field of alcohol abuse and alcoholism; and the Secretary shall recommend acceptance of any such gifts only after consultation with the Council."

58 Stat. 709. 42 USC 219.

APPROVAL BY COUNCIL OF CERTAIN GRANTS UNDER PART C OF COMMUNITY MENTAL HEALTH CENTERS ACT

Ante, p. 62.

Sec. 402. Section 266 of the Community Mental Health Centers Act is amended (1) by inserting "(other than part C thereof)" immediately after "this title", and (2) by adding immediately after the period the following: "Grants under part C

of this title for such costs may be made only upon recommendation of the National Advisory Council on Alcohol Abuse and Alcoholism established by such section."

TITLE V—GENERAL

Separability.

Sec. 501. If any section, provision, or term of this Act is adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, provision, or term of this Act, and the remaining sections, provisions, and terms shall be and remain in full force and effect.

Recordkeeping.

Sec. 502. (a) Each recipient of assistance under this Act pursuant to grants or contracts entered into under other than competitive bidding procedures shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant or contract, the total cost of the project or undertaking in connection with which such grant or contract is given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

Records, accessibility.

(b) The Secretary and Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of such recipients that are pertinent to the grants or contracts entered into under the provisions of this Act under other than competitive bidding procedures.

Payments

Sec. 503. Payments under this Act may be made in advance or by way of reimbursement and in such installments as the Secretary may determine.

Approved December 31, 1970.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 91-1663 accompanying H. R. 18874 (Comm. on Interstate and Foreign Commerce).
SENATE REPORT No. 91-1069 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 116 (1970):
Aug. 10, considered and passed Senate.
Dec. 18, considered and passed House, amended, in lieu of H.R. 18874.
Dec. 19, Senate agreed to House amendment.

APPENDIX D

COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOL PREVENTION, TREATMENT, AND REHABILITATION ACT AMENDMENTS OF 1974

PUBLIC LAW 93-282

COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT AMENDMENTS OF 1974

For Legislative History of Act, see p. 3039

PUBLIC LAW 93-282; 88 STAT. 125

[S. 1125]

An Act to extend through fiscal year 1974 certain expiring appropriations authorizations in the Public Health Service Act, the Community Mental Health Centers Act, and the Developmental Disabilities Services and Facilities Construction Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That:

TITLE I—FEDERAL ASSISTANCE FOR STATE AND LOCAL ALCOHOLISM AND ALCOHOL ABUSE PROGRAMS

PART A—SHORT TITLE; FINDINGS AND PURPOSE

SHORT TITLE

Sec. 101. This title may be cited as the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974".

FINDINGS AND PURPOSE

Sec. 102. (a) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [57] is amended by adding after section 1 the following new section:

"FINDINGS AND PURPOSE

"Sec. 2. (a) The Congress finds that—

"(1) alcohol is one of the most dangerous drugs and the drug most frequently abused in the United States;

"(2) of the Nation's estimated ninety-five million drinkers, at least nine million, or 7 per centum of the adult population, are alcohol abusers and alcoholics;

"(3) problem drinking costs the national economy at least $15,000,000,000 annually in lost working time, medical and public assistance expenditures, and police and court costs;

"(4) alcohol abuse is found with increasing frequency among persons who are multiple-drug abusers and among former heroin users who are being treated in methadone maintenance programs;

"(5) alcohol abuse is being discovered among growing numbers of youth; and

"(6) alcoholism is an illness requiring treatment and rehabilitation through the assistance of a broad range of community health and social services, and with the cooperation of law enforcement agencies.

57. 42 U.S.C.A. § 4541 et seq.

"(b) It is the policy of the United States and the purpose of this Act to (1) approach alcohol abuse and alcoholism from a comprehensive community care standpoint, and (2) meet the problems of alcohol abuse and alcoholism not only through Federal assistance to the States but also through direct Federal assistance to community-based programs meeting the urgent needs of special populations and developing methods for diverting problem drinkers from criminal justice systems into prevention and treatment programs.".

(b) The Congress declares that, in addition to the programs under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, programs under other Federal laws which provide Federal or federally assisted research, prevention, treatment, or rehabilitation in the fields of health and social services should be appropriately utilized to help eradicate alcohol abuse and alcoholism as a major problem.

PART B—GRANTS TO STATES

PROGRAM EXTENSION

Sec. 105. (a) Section 301 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [58] is amended by inserting immediately after "for each of the next two fiscal years" the following: ", $80,000,000 for the fiscal year ending June 30, 1975, and $80,000,000 for the fiscal year ending June 30, 1976,".

(b) The section heading for such section [59] is amended to read as follows:

"AUTHORIZATION FOR FORMULA GRANTS".

PROGRAM IMPROVEMENTS

Sec. 106. (a) (1) Section 302 of such Act [60] is amended by adding at the end thereof the following new subsection:

"(d) On the request of any State, the Secretary is authorized to arrange for the assignment of officers and employees of the Department or provide equipment or supplies in lieu of a portion of the allotment of such State. The allotment may be reduced by the fair market value of any equipment or supplies furnished to such State and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the State. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Secretary, but shall for purposes of determining the allotment under section 302(a), be deemed to have been paid to the State.".

(2) Section 302(b) of such Act [61] is amended (A) by striking out in the first sentence "so allotted to a State" and inserting in lieu

58. 42 U.S.C.A. § 4571.
59. 42 U.S.C.A. prec. § 4571.
60. 42 U.S.C.A. § 4572(d).
61. 42 U.S.C.A. § 4572(b).

thereof "allotted to a State in a fiscal year"; and (B) by striking out in the second sentence "for a fiscal year" and inserting in lieu thereof "in a fiscal year".

(b) Section 303(a) of such Act [62] is amended—

(1) by striking out in paragraph (3) "or groups" and inserting in lieu thereof ", of groups to be served with attention to assuring representation of minority and poverty groups";

(2) by striking out "and" at the end of paragraph (9);

(3) by redesignating paragraph (10) as paragraph (11); and

(4) by adding after paragraph (9) the following new paragraph:

"(10) set forth, in accordance with criteria to be set by the Secretary, standards (including enforcement procedures and penalties) for (A) construction and licensing of public and private treatment facilities, and (B) for other community services or resources available to assist individuals to meet problems resulting from alcohol abuse; and".

UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

Sec. 107. Part A of title III of such Act [63] is amended by adding at the end thereof the following new section:

"SPECIAL GRANTS FOR IMPLEMENTATION OF THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

"Sec. 304. (a) To assist States which have adopted the basic provisions of the Uniform Alcoholism and Intoxication Treatment Act (hereinafter in this section referred to as the 'Uniform Act') to utilize fully the protections of the Uniform Act in their efforts to approach alcohol abuse and alcoholism from a community care standpoint, the Secretary, acting through the Institute, shall, during the period beginning July 1, 1974, and ending June 30, 1977, make grants to such States for the implementation of the Uniform Act. A grant under this section to any State may only be made for that State's costs (as determined in accordance with regulations which the Secretary shall promulgate not later than July 1, 1974) in implementing the Uniform Act for a period which does not exceed one year from the first day of the first month for which the grant is made. No State may receive more than three grants under this section.

"(b) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information as the Secretary shall by regulation prescribe. The Secretary may not approve an application of a State under this section unless he determines the following:

"(1) The State and each of its political subdivisions are committed to the concept of care for alcoholism and alcohol abuse

62. 42 U.S.C.A. § 4573(a).
63. 42 U.S.C.A. § 4574.

through community health and social service agencies, and, in accordance with the purposes of sections 1 and 19 of the Uniform Act, have repealed those portions of their criminal statutes and ordinances under which drunkenness is the gravamen of a petty criminal offense, such as loitering, vagrancy, or disturbing the peace.

"(2) The laws of the State respecting acceptance of individuals into alcoholism and intoxication treatment programs are in accordance with the following standards of acceptance of individuals for such treatment (contained in section 10 of the Uniform Act):

"(A) A patient shall, if possible, be treated on a voluntary rather than an involuntary basis.

"(B) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

"(C) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

"(D) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

"(E) Provision shall be made for a continuum of coordinated treatment services so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

"(3) The laws of the State respecting involuntary commitment of alcoholics are consistent with the provisions of section 14 of the Uniform Act which protect individual rights.

"(4) The application of the State contains such assurances as the Secretary may require to carry out the purposes of this section.

For purposes of subsection (a), the term 'basic provisions of the Uniform Alcoholism and Intoxication Treatment Act' shall not in the case of a State which has a State plan approved under section 303 include any provision of the Uniform Act respecting the organization of such State's treatment programs (as defined in the Uniform Act) which are inconsistent with the requirements of such State plan.

"(c) The amount of any grant under this section to any State for any fiscal year may not exceed the sum of $100,000 and an amount equal to 10 per centum of the allotment of such State for such fiscal year under section 302 of this Act. Payments under grants under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

"(d) For the purpose of making payments under grants under this section, there are authorized to be appropriated $13,000,000 for

the fiscal year ending June 30, 1975, and for each of the next two fiscal years.".

CONFORMING AMENDMENT

Sec. 108. The heading for part A of title III of such Act [64] is amended by striking out "Formula Grants" and inserting in lieu thereof "Grants to States".

PART C—PROJECT GRANTS AND CONTRACTS

GRANTS AND CONTRACTS FOR PREVENTION AND TREATMENT PROJECTS

Sec. 111. Section 311 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [65] is amended to read as follows:

"GRANTS AND CONTRACTS FOR THE PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM

"Sec. 311. (a) The Secretary, acting through the Institute, may make grants to public and nonprofit private entities and may enter into contracts with public and private entities and with individuals—

"(1) to conduct demonstration, service, and evaluation projects,

"(2) to provide education and training,

"(3) to provide programs and services in cooperation with schools, courts, penal institutions, and other public agencies, and

"(4) to provide counseling and education activities on an individual or community basis,

for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics.

"(b) Projects and programs for which grants and contracts are made under this section shall (1) whenever possible, be community based, seek to insure care of good quality in general community care facilities and under health insurance plans, and be integrated with, and provide for the active participation of, a wide range of public and nongovernmental agencies, organizations, institutions, and individuals; and (2) where appropriate utilize existing community resources (including community mental health centers).

"(c) (1) In administering this section, the Secretary shall require coordination of all applications for projects and programs in a State.

"(2) Each applicant from within a State upon filing its application with the Secretary for a grant or contract under this section, shall submit a copy of its application for review by the State agency designated under section 303 of this Act, if such designation has been made. Such State agency shall be given not more than thirty days from the date of receipt of the application to submit to the Secretary, in writing, an evaluation of the project or program set

64. 42 U.S.C.A. § 4571 et seq.
65. 42 U.S.C.A. § 4577.

forth in the application. Such evaluation shall include comments on the relationship of the project to other projects and programs pending and approved and to the State comprehensive plan for treatment and prevention of alcohol abuse and alcoholism under section 303. The State shall furnish the applicant a copy of any such evaluation.

"(3) Approval of any application for a grant or contract by the Secretary, including the earmarking of financial assistance for a program or project, may be granted only if the application substantially meets a set of criteria established by the Secretary that—

"(A) provides that the projects and programs for which assistance under this section is sought will be substantially administered by or under the supervision of the applicant;

"(B) provides for such methods of administration as are necessary for the proper and efficient operation of such programs and projects;

"(C) provides for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for Federal funds paid to the applicant; and

"(D) provides reasonable assurance that Federal funds made available under this section for any period will be so used as to supplement and increase, to the extent feasible and practical, the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the projects and programs described in this section, and will in no event supplant such State, local, and other non-Federal funds.

"(d) To make payments under grants and contracts under this section, there are authorized to be appropriated $80,000,000 for the fiscal year ending June 30, 1975, and $95,000,000 for the fiscal year ending June 30, 1976."

PART D—ADMISSION TO HOSPITALS; CONFIDENTIALITY OF RECORDS

HOSPITAL ADMISSIONS

Sec. 121. (a) Section 321 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [66] is amended to read as follows:

"ADMISSION OF ALCOHOL ABUSERS AND ALCOHOLICS TO PRIVATE AND PUBLIC HOSPITALS

"Sec. 321. (a) Alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse or alcoholism, by any private or public general hospital which receives support in any form from any program supported in whole or in part by funds appropriated to any Federal department or agency.

66. 42 U.S.C.A. § 4581.

"(b)(1) The Secretary is authorized to make regulations for the enforcement of the policy of subsection (a) with respect to the admission and treatment of alcohol abusers and alcoholics in hospitals which receive support of any kind from any program administered by the Secretary. Such regulations shall include procedures for determining (after opportunity for a hearing if requested) if a violation of subsection (a) has occurred, notification of failure to comply with such subsection, and opportunity for a violator to comply with such subsection. If the Secretary determines that a hospital subject to such regulations has violated subsection (a) and such violation continues after an opportunity has been afforded for compliance, the Secretary may suspend or revoke, after opportunity for a hearing, all or part of any support of any kind received by such hospital from any program administered by the Secretary. The Secretray may consult with the officials responsible for the administration of any other Federal program from which such hospital receives support of any kind, with respect to the suspension or revocation of such other Federal support for such hospital.

"(2) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations prescribed by the Secretary under paragraph (1) of this subsection to the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from alcohol abuse or alcoholism. In prescribing and implementing regulations pursuant to this paragraph, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.".

(b) The Administrator of Veterans' Affairs shall submit to the appropriate committees of the House of Representatives and the Senate a full report (1) on the regulations (including guidelines, policies, and procedures thereunder) he has prescribed pursuant to section 321(b)(2) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, (2) explaining the bases for any inconsistency between such regulations and regulations of the Secretary under section 321(b)(1) of such Act, (3) on the extent, substance, and results of his consultations with the Secretary respecting the prescribing and implementation of the Administrator's regulations, and (4) containing such recommendations for legislation and administrative actions as he determines are necessary and desirable. The Administrator shall submit such report not later than sixty days after the effective date of the regulations prescribed by the Secretary under such section 321(b)(1), and shall timely publish such report in the Federal Register.

CONFIDENTIALITY

Sec. 122. (a) Section 333 of such Act[67] is amended to read as follows:

"CONFIDENTIALITY OF RECORDS

"Sec. 333. (a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

"(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

"(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

"(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

"(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

"(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necesary, shall impose appropriate safeguards against unauthorized disclosure.

"(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

"(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

67. 42 U.S.C.A. § 4582.

"(e) The prohibitions of this section do not apply to any interchange of records—

"(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

"(2) between such components and the Armed Forces.

"(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

"(g) Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

"(h) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations prescribed by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from alcohol abuse or alcoholism. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.".

(b) Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a)) [68] is amended by striking out "the use and effect of drugs" and inserting in lieu thereof "mental health, including research on the use and effect of alcohol and other psychoactive drugs,".

(c) The Administrator of Veterans' Affairs shall submit to the appropriate committees of the House of Representatives and the Senate a full report (1) on the regulations (including guidelines, policies, and procedures thereunder) he has prescribed pursuant to section 333(h) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, (2) explaining the basis for any inconsistency between such regulations and regulations of the Secretary under section 333(g) of such Act, (3) on the extent, substance, and results of his consultations with the Secretary respecting the prescribing and implementation of the Administrator's regulations, and (4) containing such recommendations for legislative and administrative actions as he determines are necessary and desirable. The Administrator shall submit such

68. 42 U.S.C.A. § 242a(a).

report not later than sixty days after the effective date of the regulations prescribed by the Secretary under such section 333(g), and shall timely publish such report in the Federal Register.

PART E—INTERAGENCY COMMITTEE

INTERAGENCY COMMITTEE

Sec. 131. Title I of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [69] is amended by adding at the end the following:

"INTERAGENCY COMMITTEE ON FEDERAL ACTIVITIES FOR ALCOHOL ABUSE AND ALCOHOLISM

"Sec. 103. (a) The Secretary shall establish an Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism (hereinafter in this section referred to as the 'Committee'). The Committee shall (1) evaluate the adequacy and technical soundness of all Federal programs and activities which relate to alcoholism and alcohol abuse and provide for the communication and exchange of information necessary to maintain the coordination and effectiveness of such programs and activities, and (2) seek to coordinate efforts undertaken to deal with alcohol abuse and alcoholism in carying out Federal health, welfare, rehabilitation, highway safety, law enforcement, and economic opportunity laws.

"(b) The Secretary or the Director of the National Institute on Alcohol Abuse and Alcoholism (or the Director's designee) shall serve as Chairman of the Committee, the membership of which shall include (1) appropriate scientific, medical, or technical representation from the Department of Transportation, the Department of Justice, the Department of Defense, the Veterans' Administration, and such other Federal agencies and offices (including appropriate agencies and offices of the Department of Health, Education, and Welfare) as the Secretary determines administer programs directly affecting alcoholism and alcohol abuse, and (2) five individuals from the general public appointed by the Secretary from individuals who by virtue of their training or experience are particularly qualified to participate in the performance of the Committee's functions. The Committee shall meet at the call of the Chairman, but not less often than four times a year.

"(c) Each appointed member of the Committee shall be appointed for a term of four years, except that—

"(1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and

"(2) of the members first appointed, two shall be appointed for a term of four years, two shall be appointed for a term of three years, and one shall be appointed for a term of one year, as designated by the Secretary at the time of appointment.

69. 42 U.S.C.A. § 4553.

Appointed members may serve after the expiration of their terms until their successors have taken office.

"(d) Appointed members of the Committee shall receive for each day they are engaged in the performance of the functions of the Committee compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule, including traveltime; and all members, while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as such expenses are authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

"(e) The Secretary shall make available to the Committee such staff, information, and other assistance as it may require to carry out its activities effectively.".

TITLE II—ADMINISTRATION AND COORDINATION OF THE NATIONAL INSTITUTE OF MENTAL HEALTH, THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, AND THE NATIONAL INSTITUTE ON DRUG ABUSE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Sec. 201. (a) The Secretary of Health, Education, and Welfare shall establish, in the Department of Health, Education, and Welfare, the Alcohol, Drug Abuse, and Mental Health Administration (hereinafter in this section referred to as the "Administration"). The Administration shall be headed by an Administrator appointed by the President, by and with the advice and consent of the Senate. The Administrator, with the approval of the Secretary, may appoint a Deputy Administrator and may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to administer the activities to be carried out through the Administration.

(b) The Secretary, acting through the Administration, shall supervise the functions of the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse in order to assure that (1) the programs carried out through each such Institute receive appropriate and equitable support, and (2) there is cooperation among the Institutes in the implementation of such programs.

(c) The Secretary of Health, Education, and Welfare shall establish a National Panel on Alcohol, Drug Abuse, and Mental Health (hereinafter in this subsection referred to as the "panel") to advise, consult with, and make recommendations to the Secretary concerning the activities to be carried out through the Administration. The panel shall consist of three members appointed by the Secretary as follows: One member shall be appointed from the public members of the National Advisory Mental Health Council established under section 217 of the Public Health Service Act, one member shall be appointed from the public members of the National Advisory Coun-

cil on Alcohol Abuse and Alcoholism established under such section, and one member shall be appointed from the public members of the National Advisory Council on Drug Abuse established under such section

NATIONAL INSTITUTE OF MENTAL HEALTH

Sec. 202. Title IV of the Public Health Service Act [70] is amended by redesignating part G as part H, by redesignating section 454 as section 461, and by inserting after part F the following new part:

"PART G—NATIONAL INSTITUTE OF MENTAL HEALTH

"ESTABLISHMENT OF INSTITUTE

"Sec. 455. (a) There is established the National Institute of Mental Health (hereinafter in this part referred to as the 'Institute') to administer the programs and authorities of the Secretary with respect to mental health. The Secretary, acting through the Institute, shall, in carrying out the purposes of sections 301 and 303 of this Act and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (other than part C of title II) with respect to mental illness, develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of mental illness and for the rehabilitation of the mentally ill. The Secretary shall carry out through the Institute the administrative and financial management, policy development and planning, evaluation, and public information functions which are required for the implementation of such programs and authorities.

"(b)(1) The Institute shall be under the direction of a Director who shall be appointed by the Secretary.

"(2) The Director, with the approval of the Secretary, may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to administer the programs and authorities to be carried out through the Institute.

"(c) The programs to be carried out through the Institute shall be administered so as to encourage the broadest possible participation of professionals and paraprofessionals in the fields of medicine, science, the social sciences, and other related disciplines."

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Sec. 203. (a) Section 101 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 [71] is amended to read as follows:

"ESTABLISHMENT OF THE INSTITUTE

"Sec. 101. (a) There is established the National Institute on Alcohol Abuse and Alcoholism (hereafter in this Act referred to as the 'Institute') to administer the programs and authorities assigned

70. 42 U.S.C.A. § 289k-1.
71. 42 U.S.C.A. § 4551.

to the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the 'Secretary') by this Act and part C of the Community Mental Health Centers Act. The Secretary, acting through the Institute, shall, in carrying out the purposes of sections 301 and 303 of the Public Health Service Act with respect to alcohol abuse and alcoholism, develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics. The Secretary shall carry out through the Institute the administrative and financial management, policy development and planning, evaluation, and public information functions which are required for the implementation of such programs and authorities.

"(b)(1) The Institute shall be under the direction of a Director who shall be appointed by the Secretary.

"(2) The Director, with the approval of the Secretary, may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to administer the programs to be carried out through the Institute.

"(c) The programs to be carried out through the Institute shall be administered so as to encourage the broadest possible participation of professionals and paraprofessionals in the fields of medicine, science, the social sciences, and other related disciplines."

(b)(1) Section 102(2) of such Act [72] is amended by inserting "and every three years thereafter" after "Act".

(2)(A) Section 102 of such Act [73] is amended by striking out "and" at the end of paragraph (3), by striking the period at the end of paragraph (4) and inserting in lieu thereof "; and", and by adding after paragraph (4) the following:

> "(5) submit to Congress on or before the end of each calendar year a report on the extent to which other Federal programs and departments are concerned and dealing effectively with the problems of alcohol abuse and alcoholism.

Before submitting a report under paragraph (5), the Secretary shall give each department and agency of the Government which (or a program of which) is referred to in the report he proposes to submit under such paragraph an opportunity to comment on the proposed report; and the Secretary shall include in the report submitted to Congress under such paragraph the comments received by him from any such department or agency within 30 days from the date the proposed report was submitted to such department or agency.".

(B) The first report to be submitted by the Secretary of Health, Education, and Welfare under section 102(5) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 shall be submitted not later than December 31, 1974.

72. 42 U.S.C.A. § 4552(2).
73. 42 U.S.C.A. § 4552(3) to (5).

NATIONAL INSTITUTE ON DRUG ABUSE

Sec. 204. Subsections (a) and (b) of section 501 of the Drug Abuse Office and Treatment Act of 1972 [74] are amended to read as follows:

"(a) There is established the National Institute on Drug Abuse (hereinafter in this section referred to as the 'Institute') to administer the programs and authorities of the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the 'Secretary') with respect to drug abuse prevention functions. The Secretary, acting through the Institute, shall, in carrying out the purposes of sections 301, 302, and 303 of the Public Health Service Act with respect to drug abuse, develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of drug abuse and for the rehabilitation of drug abusers. The Secretary shall carry out through the Institute the administrative and financial management, policy development and planning, evaluation, and public information functions which are required for the implementation of such programs and authorities.

"(b)(1) The Institute shall be under the direction of a Director who shall be appointed by the Secretary.

"(2) The Director, with the approval of the Secretary, may employ and prescribe the functions of such officers and employees, including attorneys, as are necessary to administer the programs and authorities to be carried out through the Institute.".

TITLE III—TECHNICAL AND CONFORMING AMENDMENTS

Sec. 301. Section 5108(c) of title 5, United States Code,[75] is amended—

(1) by striking out the period at the end of paragraph (10)(B) and inserting in lieu thereof a semicolon;

(2) by redesignating the paragraph (10) relating to the Law Enforcement Assistance Administration as paragraph (11) and by striking out the period at the end of that paragraph and inserting in lieu thereof a semicolon;

(3) by redesignating the paragraph (10) relating to the Chief Judge of the United States Tax Court as paragraph (12) and by striking out "and" at the end of that paragraph;

(4) by redesignating the paragraph (11) relating to the Chairman of the Equal Employment Opportunity Commission as paragraph (13) and by striking out the period at the end of that paragraph and inserting in lieu thereof "; and"; and

(5) by adding at the end thereof the following new paragraph:

"(14) the Secretary of Health, Education, and Welfare, subject to the standards and procedures prescribed by this chapter,

74. 21 U.S.C.A. § 1191(a), (b).
75. 5 U.S.C.A. § 5108(c).

may place a total of eleven positions in the National Institute on Alcohol Abuse and Alcoholism in GS–16, 17, and 18.".

Sec. 302. Section 247 of the Community Mental Health Centers Act (42 U.S.C. 2688j–2) [76] is repealed.

Sec. 303. (a) Section 408 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) [77] is amended to read as follows:

"§ 408. Confidentiality of patient records

"(a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

"(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g).

"(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

"(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

"(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

"(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

"(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

"(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

76. 42 U.S.C.A. § 2688j–2.
77. 21 U.S.C.A. § 1175.

"(e) The prohibitions of this section do not apply to any interchange of records—

"(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

"(2) between such components and the Armed Forces.

"(f) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

"(g) The Director of the Special Action Office for Drug Abuse Prevention, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Director are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.".

(b)(1) Effective on the date specified in section 104 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1104), the first sentence of section 408(g) of that Act (21 U.S.C. 1175) [78] is amended by striking "Director of the Special Action Office for Drug Abuse Prevention" and inserting in lieu thereof "Secretary of Health, Education, and Welfare", and the second sentence of such section is amended by striking "Director" and inserting "Secretary" in lieu thereof.

(2) Effective on the date specified in paragraph (1) of this subsection, section 408 of such Act [79] is further amended by—

(A) striking out "The" and inserting in lieu thereof "Except as provided in subsection (h) of this section, the" in the first sentence of subsection (g) of such section; and

(B) adding at the end of such section the following new subsection:

"(h) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations established by the Secretary under subsection (g) of this section to records maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38 to veterans suffering from drug abuse. In prescribing and implementing regulations pursuant to this subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.".

78. 21 U.S.C.A. § 1175(g).
79. 21 U.S.C.A. § 1175 note.

(c) The Administrator of Veterans' Affairs shall submit to the appropriate committees of the House of Representatives and the Senate a full report (1) on the regulations (including guidelines, policies, and procedures thereunder) he has prescribed pursuant to section 408(h) of the Drug Abuse Office and Treatment Act of 1972, (2) explaining the bases for any inconsistency between such regulations and the regulations of the Secretary of Health, Education, and Welfare under section 408(g) of that Act, (3) on the extent, substance, and results of his consultations with the Secretary respecting the prescribing and implementation of the Administrator's regulations, and (4) containing such recommendations for legislation and administrative actions as he determines are necessary and desirable. The Administrator shall submit such report not later than sixty days after the effective date of the regulations prescribed by the Secretary under such section 408(g), and shall timely publish such report in the Federal Register.

(d) Any regulation under or with respect to section 408 of the Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175) issued by the Director of the Special Action Office for Drug Abuse Prevention prior to the date specified in section 104 of that Act (21 U.S.C. 1104), whether before or after the enactment of this Act, shall remain in effect until revoked or amended by the Director or the Secretary of Health, Education, and Welfare, as the case may be.

Approved May 14, 1974.

APPENDIX E

STATE ALCOHOLISM AUTHORITIES AND PROGRAM CONTACTS

March 1976

STATE ALCOHOLISM AUTHORITIES AND PROGRAM CONTACTS

Officially Designated Authority		Program Contact
	Alabama	
Department of Mental Health 502 Washington Avenue Montgomery, Alabama 36104		Alabama State Alcoholism Program 145 Moulton Street Montgomery, Alabama 36104 Telephone: (205) 265-2301 x-235
	Alaska	
Department of Health and Social Services Pouch H Juneau, Alaska 99801		Division of Family and Childrens' Services Office of Alcoholism Pouch HO5F Juneau, Alaska 99801 Telephone: (907) 586-6201
	Arizona	
Department of Health Services State Health Building 1740 West Adams Street Phoenix, Arizona 85007		Community Programs 2500 East Van Buren Street Phoenix, Arizona 85008 Telephone: (602) 271-3438
	Arkansas	
Department of Social and Rehabilitative Services 406 National Old Line Building Little Rock, Arkansas 72201		Office on Alcohol Abuse and Alcoholism 1515 West 7th Street, Suite 202 Little Rock, Arkansas 72202 Telephone (501) 371-2003
	California	
Office of Alcoholism 825 - 15th Street Sacramento, California 95814		Office of Alcoholism 825 - 15th Street Sacramento, California 95814 Telephone: (916) 445-1940
	Colorado	
Department of Health 4210 East 11th Street Denver, Colorado 80220		Alcohol and Drug Abuse Division 4210 East 11th Street Denver, Colorado 80220 Telephone: (303) 388-6111
	Connecticut	
Connecticut State Alcohol Council 90 Washington Street Hartford, Connecticut 06115		Connecticut State Alcohol Council 90 Washington Street Hartford, Connecticut 06115 Telephone: (203) 566-3464
	Delaware	
Department of Health and Social Services Delaware State Hospital New Castle, Delaware 19720		Bureau of Substance Abuse 3000 Newport Gap Pike Wilmington, Delaware 19808 Telephone: (302) 998-0438

Officially Designated Authority		Program Contact
	District of Columbia	
Department of Human Resources District Building Washington, D.C. 20004		Department of Human Resources District Building Washington, D.C. 20004 Telephone: (202) 629-5443
	Florida	
Department of Health and Rehabilitative Services 1323 Winewood Boulevard Tallahassee, Florida 32301		Mental Health Program Office Alcoholic Rehabilitation Program 1309 Winewood Boulevard, R. 336 Tallahassee, Florida 32301 Telephone: (904) 488-9955
	Guam	
Division of Mental Health Guam Memorial Hospital Agana, Guam 96910		Drug and Alcohol Coordinator Guam Memorial Hospital Agana, Guam 96910
	Georgia	
Department of Human Resources 47 Trinity Avenue, S.W. Atlanta, Georgia 30334		Devision of Mental Health Alcohol & Drug Abuse Services Section 618 Ponce De Leon Avenue, N.E. Atlanta, Georgai 30308 Telephone: (404) 894-4785
	Hawaii	
Department of Health 1250 Punchbowl Street Honolulu, Hawaii 96813		Substance Abuse Agency 1270 Queen Emma Street Room 404 Honolulu, Hawaii 96813 Telephone: (808) 548-7655
	Idaho	
Department of Health and Welfare Statehouse Boise, Idaho 83720		Bureau of Substance Abuse Statehouse, LBJ Building Boise, Idaho 83720 Telephone: (208) 384-3920
	Illinois	
Department of Mental Health and Developmental Disabilities 160 North LaSalle Street Chicago, Illinois 60601		Department of Mental Health and Developmental Disabilities Alcoholism Division 188 West Randolph St., Rm. 1900 Telephone: (312) 793-2907
	Indiana	
Department of Mental Health 1315 West Tenth Street Indianapolis, Indiana 46202		Division of Addiction Services Five Indiana Square Indianapolis, Indiana 46204 Telephone: (317) 633-4477
	Iowa	
Division on Alcoholism Lucas State Office Building Des Moines, Iowa 50319		Division on Alcoholism Lucas State Office Building Des Moines, Iowa 50319 Telephone: (515) 281-5604

Officially Designated Authority		Program Contact
	Kansas	
Department of Social and Rehabilitation Services 6th Fl., State Office Building Topeka, Kansas 66612		Alcohol and Drug Abuse Section 535 Kansas Avenue, Room 1106 Topeka, Kansas 66603 Telephone: (913) 296-3991
	Kentucky	
Department for Human Resources Capitol Annex Frankfort, Kentucky 40601		Bureau for Health Services 275 East Main Street Frankfort, Kentucky 40601 Telephone (502) 564-3970
	Louisiana	
Division of Hospitals 200 Lafayette Street Seventh Floor, Weber Building Baton Rouge, Louisiana 70801		Bureau of Substance Abuse 200 Lafayette Street Seventh Floor, Weber Building Baton Rouge, Louisiana 70801 Telephone: (504) 389-2534
	Maine	
Department of Health and Welfare Statehouse Augusta, Maine 04330		Bureau of Rehabilitation Office of Alcoholism and Drug Abuse Prevention 32 Winthrop Street Augusta, Maine 04330 Telephone: (207) 289-2141
	Maryland	
Department of Health and Mental Hygiene 201 West Preston Street Baltimore, Maryland 21201		Division of Alcoholism Control 201 West Preston Street Baltimore, Maryland 21201 Telephone: (301) 383-2782
	Massachusetts	
Department of Public Health 600 Washington Street, Room 214 Boston, Massachusetts 02111		Division of Alcoholism 755 Boylston Street Boston, Massachusetts 02116 Telephone: (617) 536-6983
	Michigan	
Department of Public Health 3500 North Logan Street Lansing, Michigan 48914		Office of Substance Abuse Ser. 3500 North Logan Street Lansing, Michigan 48914 Telephone: (517) 373-8600
	Minnesota	
Department of Public Welfare Centennial Office Building 4th Floor Saint Paul, Minnesota 55155		Chemical Dependency Program Division Metro Square Building, Room 402 Saint Paul, Minnesota 55101 Telephone: (612) 296-4610
	Mississippi	
Department of Mental Health 607 Robert E. Lee Office Bldg. Jackson, Mississippi 39201		Division of Alcohol Abuse and Alcoholism 125 Lelia Court Jackson, Mississippi 39216 Telephone: (601) 354-7031

Officially Designated Authority		Program Contact
	Missouri	
Department of Mental Health 722 Jefferson Street Jefferson City, Missouri 65101		Division of Alcoholism and Drug Abuse P. O. Box 687 2002 Missouri Boulevard Jefferson City, Missouri 65101 Telephone (314) 751-4122
	Montana	
Department of Institutions 1539 11th Avenue Helena, Montana 59601		Division of Addictive Diseases 1539 11th Avenue Helena, Montana 59601 Telephone (406) 449-3965
	Nebraska	
Division on Alcoholism Box 94728 Lincoln, Nebraska 68509		Division on Alcoholism Box 94728 Lincoln, Nebrasia 68509 Telephone: (402) 471-2851
	Nevada	
Department of Human Resources 308 North Curry Street Carson City, Nevada 89701		Bureau of Alcohol and Drug Abuse 505 E. King Street 5th Floor Kinkead Carson City, Nevada 89701 Telephone: (702) 885-4790
	New Hampshire	
Governor Statehouse Concord, New Hampshire 03301		Program on Alcohol and Drug Abus 61 South Spring Street Concord, New Hampshire 03301 Telephone: (603) 271-3531
	New Jersey	
State Department of Health P. O. Box 1540, John Ritch Plaza Trenton, New Jersey 08625		Alcohol, Narcotics, & Drug Abuse Unit P. O. Box 1540, John Fitch Plaza Trenton, New Jersey 08625 Telephone: (609) 292-8947
	New Mexico	
Department of Hospitals and Institutions 425 Old Santa Fe Trail Santa Fe, New Mexico 87501		New Mexico Commission on Alcoholism P. O. Box 1731 Albuquerque, New Mexico 87103 Telephone: (505) 827-3251
	New York	
Department of Mental Hygiene 44 Holland Avenue Albany, New York 12208		Division of Alcoholism 44 Holland Avenue Albany, New York 12208 Telephone: (518) 474-5417

Officially Designated Authority		Program Contact
	North Carolina	
Department of Human Resources P. O. Box 26327 Raleigh, North Carolina 27611		Division of Mental Health Ser. Alcohol and Drug Services P. O. Box 26327 Raleigh, North Carolina 27611 Telephone: (919) 82904670
	North Dakota	
State Department of Health State Capitol Bismarck, North Dakota 58501		Division of Alcoholism and Drug Abuse 909 Basin Avenue Bismarck, North Dakota 58505 Telephone: (701) 224-2767
	Ohio	
Ohio Department of Health 450 East Town Street P. O. Box 118 Columbus, Ohio 43216		Alcoholism Unit 450 East Town Street P. O. Box 118 Columbus, Ohio 43216 Telephone: (614) 466-3445
	Oklahoma	
Department of Mental Health 408-A North Walnut Street Oklahoma City, Oklahoma 73105		Division of Alcoholism 408-A North Walnut Street Oklahoma City, Oklahoma 73105 Telephone: (405) 521-2811
	Oregon	
Department of Human Resources 318 Public Services Building Salem, Oregon 97310		Mental Health Division Programs for Alcohol and Drug 2570 Center Street, N. E. Salem, Oregon 97310 Telephone: (503) 378-2163
	Pennsylvania	
Governor's Council on Drug and Alcohol Abuse Office of the Governor Commonwealth of Pennsylvania 2101 North Front Street Harrisburg, Pennsylvania 17110		Governor's Council on Drug and Alcohol Abuse Office of the Governor Commonwealth of Pennsylvania 2101 North Front Street Harrisburg, Pennsylvania 17110 Telephone: (717) 787-9857
	Puerto Rico	
Department of Addiction Services Box B-Y Rio Piedras, Puerto Rico 00928		State Alcoholism Program Assistant Secretary for Alcoholism Box B-Y Rio Piedras, Puerto Rico 00928 Telephone: (809) 763-7575
	Rhode Island	
Department of Mental Health, Retardation and Hospitals The Aime J. Forand Building 600 New London Avenue Cranston, Rhode Island 02920		Services for Alcoholics The Aime J. Forand Building 600 New London Avenue Cranston, Rhode Island 02920 Telephone: (401) 464-3291

Officially Designated Authority		Program Contact
	American Samoa	
Department of Health Pago Pago, American Samoa		Department of Health Pago Pago, American Samoa
	South Carolina	
South Carolina Commission on Alcohol and Drug Abuse P. O. Box 4616, Landmark East 3700 Forest Drive, Suite 300 Columbia, South Carolina 29240		South Carolina Commission on Alcohol and Drug Abuse P. O. Box 4616, Landmark East 3700 Forest Drive, Suite 300 Columbia, South Carolins 29240 Telephone: (803) 758-2521
	South Dakota	
Department of Health Foss Building Pierre, South Dakota 57501		Division of Alcoholism Office Building No. 2 State Capitol Pierre, South Dakota 57501 Telephone: (803) 758-2521
	Tennessee	
Department of Mental Health Capitol Blvd. Bldg. 226 Capitol Blvd. Nashville, Tennessee 37219		Section on Alcohol and Drugs Capitol Blvd. Bldg. 226 Capitol Blvd. Nashville, Tennessee 37219 Telephone: (615) 741-1921
	Texas	
Texas Commission on Alcoholism 809 Sam Houston State Office Building Austin, Texas 78701		Texas Commission on Alcoholism 809 Sam Houston State Office Bldg. Austin, Texas 78701 Telephone: (512) 475-2577
	Trust Territory of the Pacific Islands	
Department of Health Services Office of the High Commissioner Saipan, Mariana Islands 96950		Division of Mental Health Saipan, Mariana Islands 96950
	Utah	
Department of Social Services State Capitol Building, Room 221 Salt Lake City, Utah, 84114		Division of Alcoholism and Drugs 554 South 300 East Street Salt Lake City, Utah 84111 Telephone: (801) 328-6532
	Vermont	
Agency of Human Services Office of Secretary State Office Building Montpelier, Vermont 05602		Alcohol and Drug Abuse Division 81 River Street Montpelier, Vermont 05602 Telephone: (802) 828-2721
	Virginia	
Department of Health James Madison Building 109 Governor Street Richmond, Virginia 23219		Bureau of Alcohol Studies and Rehabilitation James Madison Building Richmond, Virginia 23219 Telephone: (804) 786-3082

Officially Designated Authority		Program Contact
	Virgin Islands	
Department of Health P. O. Box 1442 St. Thomas, U.S. Virgin Islands 00801		Mental Health Services P. O. Box 1442 St. Thomas, U.S. Virgin Islands 00801 Telephone: (809) 774-0117
	Washington	
Department of Social and Health Services Public Lands Building Olympia, Washington 98504		Office of Alcoholism Mailstop 45-1 Olympia, Washington 98504 Telephone: (206) 753-5866
	West Virginia	
Department of Mental Health State Capitol Charleston, West Virginia 25305		Division on Alcoholism and Drug Abuse State Capitol Charleston, West Virginia 25305 Telephone: (304) 348-3616
	Wisconsin	
Department of Health and Social Services 1 West Wilson Street Madison, Wisconsin 53702		Bureau of Alcoholism and Other Drug Abuse 1 West Wilson Street Madison, Wisconsin 53702 Telephone: (608) 266-3442
	Wyoming	
Division of Health and Medical Services State Office Building Cheyenne, Wyoming 82001		Mental Health and Mental Retardation Services State Office Building Cheyenne, Wyoming 82001 Telephone: (307) 777-7351

APPENDIX F

MAJORITY OPINION, U.S. SUPREME COURT, POWELL v. TEXAS, 392 U.S. 514 (1968)

POWELL v. TEXAS
392 U.S. 514 (1968)

Mr. Justice Marshall announced the judgment of the Court and delivered an opinion in which the Chief Justice, Mr. Justice Black, and Mr. Justice Harlan join.

In late December 1966, appellant was arrested and charged with being found in a state of intoxication in a public place, in violation of Texas Penal Code, Art. 477 (1952), which reads as follows:

> "Whoever shall get drunk or be found in a state of intoxication in any public place, or at any private house except his own, shall be fined not exceeding one hundred dollars."

Appellant was tried in the Corporation Court of Austin, Texas, found guilty, and fined $20. He appealed to the County Court at Law No. 1 of Travis County, Texas, where a trial de novo was held. His counsel urged that appellant was "afflicted with the disease of chronic alcoholism," that "his appearance in public (while drunk was)...not of his own volition," and therefore that to punish him criminally for that conduct would be cruel and unusual, in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

The trial judge in the county court, sitting without a jury, made certain findings of fact, but ruled as a matter of law that chronic alcoholism was not a defense to the charge. He found appellant guilty, and fined him $50. There being no further right to appeal within the Texas judicial system, appellant appealed to this Court; we noted probable jurisdiction.

I.

In the first place, the record in this case is utterly inadequate to permit the sort of informed and responsible adjudication which alone can support the announcement of an important and wide-ranging new constitutional principle. We know very little about the circumstances surrounding the drinking bout which resulted in this conviction, or about Leroy Powell's drinking problem, or indeed about alcoholism itself. The trial hardly reflects the sharp legal and evidentiary clash between fully prepared adversary litigants which is traditionally expected in major constitutional cases. The State put on only one witness, the arresting officer. The defense put on three—a policeman who testified to appellant's long history of arrests for public drunkenness, the psychiatrist, and appellant himself.

Furthermore, the inescapable fact is that there is no agreement among members of the medical profession about what it means to say that "alcoholism" is a "disease."

Nor is there any substantial consensus as to the "manifestations of alcoholism."

Dr. Wade did testify that once appellant began drinking he appeared to have no control over the amount of alcohol he finally ingested. Appellant's own testimony concerning his drinking on the day of the trial would certainly appear, however, to cast doubt upon the conclusion that he was without control over his consumption of alcohol when he had sufficiently important reasons to exercise such control. However that may be, there are more serious factual and conceptual difficulties with reading this record to show that appellant was unable to abstain from drinking. Dr. Wade testified that when appellant was sober, the act of taking the first drink was a "voluntary exercise of his will," but that this exercise of will was undertaken under the "exceedingly strong influence" of a "compulsion" which was "not completely overpowering." Such concepts, when juxtaposed in this fashion, have little meaning.

Moreover, Jellinek asserts that it cannot accurately be said that a person is truly unable to abstain from drinking unless he is suffering the physical symptoms of withdrawal. There is no testimony in this record that Leroy Powell underwent withdrawal symptoms either before he began the drinking spree which resulted in the conviction under review here, or at any other time.

II.

Despite the comparatively primitive state of our knowledge on the subject, it cannot be denied that the destructive use of alcoholic beverages is one of our principal social and public health problems. The lowest current informed estimate places the number of "alcoholics" in America (definitional problems aside) at 4,000,000, and most authorities are inclined to put the figure considerably higher. Nor can it be gainsaid that the legislative response to this enormous problem has in general been inadequate.

There is as yet no known generally effective method for treating the vast numbers of alcoholics in our society. Some individual alcoholics have responded to particular forms of therapy with remissions of their symptomatic dependence upon the drug. But just as there is no agreement among doctors and social workers with respect to the causes of alcoholism, there is no consensus as to why particular treatments have been effective in particular cases and there is no generally agreed-upon approach to the problem of treatment on a large scale. Most psychiatrists are apparently of the opinion that alcoholism is far more difficult to treat than other forms of behavioral disorders, and some believe it is impossible to cure by means of psychotherapy; indeed, the medical profession as a whole, and psychiatrists in particular, have been severely criticised for the prevailing reluctance to undertake the treatment of drinking problems. Thus it is entirely possible that, even were the manpower and facilities available for a full-scale attack upon chronic alcoholism, we would find ourselves unable to help the vast bulk of our "visible"—let alone our "invisible"—alcoholic population.

However, facilities for the attempted treatment of indigent alcoholics are woefully lacking throughout the country.[22] It would be tragic to return large numbers of helpless, sometimes dangerous and frequently unsanitary inebriates to the streets of our cities without even the opportunity to sober up adequately which a brief jail term provides. Presumably no State or city will tolerate such a state of affairs. Yet the medical profession cannot, and does not, tell us with any assurance that, even if the buildings, equipment and trained personnel were made available, it could provide anything more than slightly higher-class jails for our indigent habitual inebriates. Thus we run the grave risk that nothing will be accomplished beyond the hanging of a new sign—reading "hospital"—over one wing of the jailhouse.

One virtue of the criminal process is, at least that the duration of penal incarceration typically has some outside statutory limit; this is universally true in the case of petty offenses, such as public drunkenness, where jail terms are quite short on the whole. "Therapeutic civil commitment" lacks this feature; one is typically committed until one is "cured." Thus, to do otherwise than affirm might subject indigent alcoholics to the risk that they may be locked up for an indefinite period of time under the same conditions as before, with no more hope than before of receiving effective treatment and no prospect of periodic "freedom."

Faced with this unpleasant reality, we are unable to assert that the use of the criminal process as a means of dealing with the public aspects of problem drinking can never be defended as rational. The picture of the penniless drunk propelled aimlessly and endlessly through the law's "revolving door" of arrest, incarceration, release and rearrest is not a pretty one. But before we condemn the present practice across-the-board, perhaps we ought to be able to point to some clear promise of a better world for these unfortunate people. Unfortunately, no such promise has yet been forthcoming. If, in addition to the absence of a coherent approach to the problem of treatment, we

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[22] Encouraging pilot projects do exist. See President's Commission on Law Enforcement and Administration of Justice, Task Force Report: Drunkenness 50-64, 82-108 (1967). But the President's Commission concluded that the "strongest barrier" to the abandonment of the current use of the criminal process to deal with public intoxication "is that there presently are no clear alternatives for taking into custody and treating those who are now arrested as drunks." President's Commission on Law Enforcement and Administration of Justice, The Challenge of Crime in a Free Society 235 (1967). Moreover, even if massive expenditures for physical plants were forthcoming, there is a woeful shortage of trained personnel to man them. One study has concluded that:

"(T)here is little likelihood that the number of workers in these fields could be sufficiently increased to treat even a large minority of problem drinkers. In California, for instance, according to the best estimate available, providing all problem drinkers with weekly contact with a psychiatrist and once-a-month contact with a social worker would require the full time work of every psychiatrist and every trained social worker in the United States." Cooperative Commission on Study of Alcoholism, Alcohol Problems 120 (1967) (emphasis in original).

consider the almost complete absence of facilities and manpower for the implementation of a rehabilitation program, it is difficult to say in the present context that the criminal process is utterly lacking in social value. This Court has never held that anything in the Constitution requires that penal sanctions be designed solely to achieve therapeutic or rehabilitative effects, and it can hardly be said with assurance that incarceration serves such purposes any better for the general run of criminals than it does for public drunks.

Ignorance likewise impedes our assessment of the deterrent effect of criminal sanctions for public drunkenness. The fact that a high percentage of Americal alcoholics conceal their drinking problems, not merely by avoiding public displays of intoxication but also by shunning all forms of treatment, is indicative that some powerful deterrent operates to inhibit the public revelation of the existence of alcoholism. Quite probably this deterrent effect can be largely attributed to the harsh moral attitude which our society has traditionally taken toward intoxication and the shame which we have associated with alcoholism. Criminal conviction represents the degrading public revelation of what Anglo-American society has long condemned as a moral defect, and the existence of criminal sanctions may serve to reinforce this cultural taboo, just as we presume they serve to reinforce other, stronger feelings against murder, rape, theft, and other forms of antisocial conduct.

Obviously, chronic alcoholics have not been deterred from drinking to excess by the existence of criminal sanctions against public drunkenness. But all those who violate penal laws of any kind are by definition undeterred. The long-standing and still raging debate over the validity of the deterrence justification for penal sanctions has not reached any sufficiently clear conclusions to permit it to be said that such sanctions are ineffective in any particular context or for any particular group of people who are able to appreciate the consequences of their acts. Certainly no effort was made at the trial of this case, beyond a monosyllabic answer to a perfunctory one-line question, to determine the effectiveness of penal sanctions in deterring Leroy Powell in particular or chronic alcoholics in general from drinking at all or from getting drunk in particular places or at particular times.

Affirmed.

(Justices Fortas, Douglas, Brennan and Stewart dissented.)[1]

[1]Frank F. Remington, Donald F. Newman, Edward L. Kimball, Marygold Melli, and Herman Goldstein, Criminal Justice Administration Materials and Cases (The Bobbs-Merrill Company, Inc., 1969), pp. 1240-1244.

APPENDIX G

EXAMPLES OF FORMS AND DIRECTIVES USED BY VARIOUS LAW ENFORCEMENT AGENCIES IN CONNECTION WITH THEIR RESPONSIBILITIES UNDER THE UNIFORM ACT AS ENACTED BY THEIR RESPECTIVE STATES

G-1: "Report of Law Enforcement Officer"

Form used by State of Florida law enforcement officers during admittance procedures for inebriates at treatment centers.

G-2: "Law Enforcement Escort Data"

Form used in San Diego County (California) which is completed by a law enforcement officer at a treatment center after he has escorted an inebriate to the facility.

APPENDIX G-1

"Report of Law Enforcement Officer"

Form used by State of Florida law enforcement officers during admittance procedures for inebriates at treatment centers.

REPORT OF LAW ENFORCEMENT OFFICER

STATE OF FLORIDA, COUNTY OF _____, FLORIDA,

TO _____
(Receiving Facility and Address)

Pursuant to Chapter 396.072 or Chapter 396.092 or Chapter 396.102, Florida Statutes, a written report detailing the circumstances under which

_____ was taken into custody, follows:

Time and Date _____ Location Found _____

Behavior Observed _____

_____

_____
(use other side, if needed)

Family Members or others present when patient was taken into custody:

Name _____ Name _____

Address _____ Address _____

Relationship _____ Relationship _____

Telephone No. _____ Telephone No. _____

Indicate personal knowledge by family members and others about patient _____

_____

Physical Restraints, if any _____

Did the patient appear to be suffering from intoxication and likely to injure himself or others if not immediately confined? _____

Delivered to Receiving Facility on _____, 19___, at _____a.m./p.m.

Date _____ _____
(Law Enforcement Officer)

(By authority of Chapters 396.072, 396,092, 396.102 Florida Statutes)
Use back of page for additional information.

(Instructions: To be completed by Peace Officer on delivery of subject to treatment facility. Distribute copies as follows: pink - treatment facility, green - peace officer.)

rm DMH-MA-2 (Rev. 1-74)

APPENDIX G-2

"Law Enforcement Escort Data"

Form used in San Diego County (California) which is completed by a law enforcement officer at a treatment center after he has escorted an inebriate to the facility.

LAW ENFORCEMENT ESCORT DATA

DATE TIME LOCATION OF CONTACT

NAME (LAST) (FIRST) (MIDDLE)

ADDRESS

REMARKS

OFFICER'S PRINTED NAME LAW ENFORCEMENT AGENCY

OFFICER'S SIGNATURE I. D. NUMBER

ADC - 9 (3/75) ALCOHOL DETOXIFICATION CENTER

(To be completed in original and one copy. Original to law enforcement officer, copy to treatment facility.)

APPENDIX H

"SUMMARY OF RECOMMENDATIONS"

Report of the President's
Commission on Crime in
the District of Columbia

SUMMARY OF RECOMMENDATIONS[1]

IMMEDIATE ACTION

1. All persons detained for public intoxication or for being drunk and disorderly should be taken initially to a medical facility.

2. The Department of Public Health should assign sufficient personnel to the D.C. Branch of the Court of General Sessions so that all persons detained for public intoxication or drunk and disorderly can be promptly diagnosed.

3. The Corporation Counsel should prosecute only those public intoxication and drunk and disorderly defendants who have not been already adjudged to be chronic alcoholics and should raise the defense of chronic alcoholism where appropriate in any criminal case.

4. The Legal Aid Agency should assign an attorney to the D.C. Branch of the Court of General Sessions.

5. The Alcoholic Rehabilitation Clinic staff should be increased so that outpatient services can be offered to adjudicated chronic alcoholics and voluntary patients and so that weekend and evening hours can be established.

6. The Rehabilitation Center for Alcoholics at the former Women's Reformatory at Lorton should be established as a temporary facility with the full range of planned treatment services.

7. Supplemental appropriations for fiscal year 1967 should be sought for high-priority services and facilities: expanded detoxification centers, an inpatient diagnostic and treatment center in the District, and a comprehensive aftercare program including residential families.

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[1] Report of the President's Commission on Crime in the District of Columbia (Washington, D.C.: U.S. Government Printing Office, 1966), pp. 502, 503.

LONG-TERM ACTION

8. The Department of Public Health should become the central planning agency for the treatment of alcoholism and should develop a comprehensive treatment program for persons with drinking problems. All other agencies with related programs should be required to plan and coordinate their activities in accord with Department of Public Health supervision. In order to execute these duties properly, the Department of Public Health should enlarge its Office of Drug Addiction and Alcoholism Program Development and enlist the assistance of expert consultants.

9. The public intoxication statute should be amended to require disorderly behavior as en element of the offense.

10. Police and public health personnel should be authorized by statute to take into protective custody intoxicated persons who are incapacitated.

11. All persons arrested for disorderly intoxication or taken into protective custody as incapacitated inebriates should be taken to an emergency care unit for medical attention and diagnosis followed by appropriate prosecutive action or treatment referral.

12. The Corporation Counsel should be guided in his exercise of prosecutive discretion by Department of Public Health diagnostic experts.

13. The Court of General Sessions should develop a uniform sentencing policy for disorderly inebriates.

14. The Alcoholic Rehabilitation Unit of the Probation Department of the Court of General Sessions should be disbanded.

15. Under the guidance of the Department of Public Health, the Department of Corrections should establish a treatment program for prisoners with drinking problems.

16. After an appropriate period of experimentation with voluntary treatment of alcoholics under a comprehensive program, the Judicial Conference of the District of Columbia should consider the need for and the constitutionality of a civil commitment statute for chronic alcoholics and amendment of the existing Rehabilitation of Alcoholics statute.

APPENDIX I

IACP TRAINING KEY:

"DIABETES"

TRAINING KEY #49

DIABETES

You observe a person walking with a pronounced unsteadiness. His erratic gait causes him to bump into another. There is a heated exchange of words and the apparently intoxicated person becomes highly excited and belligerent. You take action as you wish to maintain order—so the "drunk" is arrested. But wait! Can't there be something else the matter?

Your attention is attracted by a derelict lying in an alley. His breath is deep and labored and reeks of a strong alcoholic odor. It is apparent that he has vomitted. Is this the case of another "wino" who has passed out?

Situations such as these are common and behavior such as described above is at times hastily interpreted to be another case of public intoxication. However, exceptions exist and the prudent officer regardless of the number of drunk arrests he has made, never takes anything for granted. He handles each case individually and makes certain that his prisoner is neither ill nor injured.

This *Training Key* will discuss the disease called Diabetes. Its objective is to acquaint the police officer with the problems and symptoms of this condition. Special emphasis is made of two critical conditions which a police officer may encounter—*insulin reaction* and *diabetic coma*.

What Is Diabetes?

There are an estimated three million persons in the United States suffering from diabetes. About half, unaware they have this condition, may pose a potential problem for the police officer as the "town drunk" or "skid row bum". The American Diabetes Association further estimates that there are about 4½ million Americans presently living who will develop the disease.

Diabetes, or *diabetes mellitus*, as it is called professionally, is an illness resulting from an insulin defficiency. This condition is related to the inability of the pancreas, a gland located in the abdomen, to produce and release insulin into the blood stream. Insulin is a hormone governing the rate in which body cells use the blood sugar for energy.

Much of the food a person eats is converted into sugar which supplies the fuel energy necessary to maintain the vital body functions. During the digestive processes, foods especially those containing a high starch or sugar content (carbohydrates), are converted into a body sugar called *glucose*. When the pancreas is properly functioning it produces enough insulin and the sugar is used up by the body cells. If the body does not require all of the glucose the excess is stored for future use in the liver or the muscle tissue or as fat.

A malfunctioning pancreas is unable to produce insulin to meet the body needs. As a result the body cells cannot absorb the sugar, and the glucose remains in the blood. Food which is then eaten is still converted into sugar (glucose), but as it is not removed from the blood to supply the cells or is not stored in the tissue, the blood sugar content rises above the body's normal limit. The kidneys, which act as the body's filtering and purifying agent become overtaxed eliminating the abnormal amount of sugar from the blood stream. Fluid must be drawn from the body tissues increasing the amount of water eliminated and accounting for the sugar content in the urine. A constant thirst caused by the need to replenish the body fluids is one of the several symptoms related to an increased amount of sugar in the blood.

Because the body cells are deprived of the energy generated by the sugar, a person with undetected or unattended diabetes becomes weak and tires easily. The body cells are forced to compensate by turning to the body fats and proteins. As this alternate source of energy is expended there is a noticeable loss of weight even though the appetite has increased. If this condition is not brought to the attention of a physician the breakdown of body fats becomes excessive. Substances known as ketone bodies are then produced and accumulate in the blood and urine. These may cause acute acidosis and result in a diabetic coma. The excess acid (acetone) in the system accounts for the fruit like breath odor on some diabetics.

COMMON SYMPTOMS*

☐ Excessive thirst	☐ Slow healing of cuts & bruises
☐ Frequent urination	☐ Changes in vision
☐ Constant hunger	☐ Intense body itching
☐ Loss of weight	☐ Pain in finger and toe
☐ Fatigue	☐ Drowsiness

* *In milder cases, only one or two of these symptoms may be present.*

TABLE I

Who Is The Diabetic?

The actual cause of diabetes is not known and anyone may develop this disease. However, considerable studies show that there are certain people who appear to be predisposed to this illness.

BLOOD RELATIVES OF DIABETICS: The tendency to get diabetes is inherited. The American Diabetes Association finds that diabetes is at least five time more prevalent among persons who have diabetes as blood relatives. However, this tendency cannot be inherited from one side of the family. This means that if a wife is a diabetic and the husband is neither diabetic nor a carrier of diabetes, the

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children will not generally develop the illness. But, if two diabetics marry, all of their children will eventually become diabetic.

OLDER PERSONS: Diabetes is rare in babies and not to common in children under 15 years of age. It generally occurs in adult life and most often in persons over forty years of age. After forty, the frequency of diabetes is five times greater.

AGE	CASES OF DIABETES
1-20	1 out of 2,500
20-40	1 out of 1,000
40-50	1 out of 200
50-60	1 out of 100
60-70	1 out of 50

TABLE II[1]

OVERWEIGHT PERSONS: Numerous studies have shown that about eighty per cent of the known diabetics were overweight before developing the disease. One explanation offered is that the overweight person usually over eats. This in turn places a greater demand upon the pancreas than its ability to produce insulin—resulting in diabetes. The death rate for diabetes was also found to be four times greater among the overweight patients.

ILLNESS AFFECTS MORE WOMEN THAN MEN: Women account for about two-thirds of all diabetic patients. In the first twenty-five years of life sex has little influence. However, in later years women acquire the disease at a faster rate than men. It also has been found that married women are more vulnerable than single women.

Living With Diabetes:

Today's treatments and knowledge of the disease allows the person suffering from this illness to live a long and productive life. Most diabetics can work actively and successfully in every occupation. The extent of diabetic management and control is exemplified by the fact that some well known athletes have diabetes. Complications normally associated with this condition, such as hardening of the arteries (which appears at an earlier age in diabetics), eye trouble and circulatory deficiencies appear gradually and may be prevented or delayed by proper and early treatment of the diabetes.

A diabetic can usually manage his condition by following the advice of his physician and making a few adjustments in his living habits. Thus, by periodic physical examinations and faithfully adhering to the IDE formula—insulin, diet and exercise—the diabetic can engage in normal activities.

INSULIN: In 1921, two Canadian researchers discovered they could sustain life by injecting an extract obtained from the pancreas of a healthy dog into dogs with diabetes. In January 1922, the two scientists, Dr. Frederick Bunting and his assistant, Charles Best, injected their first patient with the hormone. In those days a diabetic adult had a life expectancy of about 10 years. Today the life expectancy of the diabetic approaches normal.

Insulin is obtained from the pancreas of livestock. It can only be administered by injection. Although science has devoted considerable research to develop an oral dosage no progress has yet been made to prevent the digestive juices from destroying the effectiveness of the hormone. In recent years, an oral medication which reduces the sugar content of the blood has been discovered. However, it is not a substitute for insulin and is only effective with certain diabetic patients.

DIET and EXERCISE: A proper diet can regulate the sugar intake into the system and sometimes can be the controlling agent in the milder forms of diabetes. Avoiding starchy foods or those having a high sugar content helps to keep the blood sugar content near normal.

Even moderate exercising places an additional demand for body energy resulting in the use of body sugar. The diabetic or older person should consult his physician for prescribed exercises. Strenuous exercising, if not properly managed, can be a factor in a hypoglycemic attack commonly called an insulin reaction.

Insulin Reaction

An insulin reaction occurs when the blood sugar level is less than normal. This condition may result when a diabetic overexercises or engages in strenuous work without taking proper precautions. It can also be caused by injecting an excessive amount of insulin or by waiting too long between meals.

This reaction develops quickly and may prevent the victim from counteracting the effects of the blood sugar deficiency. Emergency treatment consists of an immediate introduction of carbohydrate food into the system—**soda crackers, soft drinks, orange juice, candy bar, sugar, etc.** Many diabetics carry sugar and the like for use in these emergency situations.

Severe insulin reactions present the police officer with a serious problem of identification, if the victim is unconscious and does not carry credentials identifying him as a diabetic. The symptoms closely resemble intoxication. Common to insulin reaction are **nervous instability, belligerency, thickness of speech, laughing or crying without cause, staggering and impaired coordination.** Extreme cases further reflect a close resemblance to acute alcoholism as the victim may suffer **convulsions, lose bladder control, become paralyzed and lapse into unconsciousness.** In view of the similarity existing between insulin reaction and intoxication, guard against snap judgments. *Never take a person's condition for granted.* The "wino" or known alcoholic may just as likely be a diabetic as the well dressed business man. Never detain a "drunk" before inquiring of his condition or checking his identification. Don't allow expediency or carelessness to overshadow common sense and lead you to jail the unconscious "drunk" without first obtaining a medical examination.

Diabetic Coma

When carbohydrates are eliminated or reduced to a minimum by restricting the food intake (dieting) or when they can no longer be changed into energy because of illness (unattended diabetes), body fat are used up. In turn if too much dependency is placed upon this source of energy, an acid reaction occurs which poisons the system leading to a diabetic coma and death.

A diabetic coma usually results from a neglect or

[1] *Facts About Diabetes*, American Diabetes Association, Inc., 1956, p. 3.

the victim's part to follow a prescribed diet and to take his medication.

Today the coma victim is rare and when it occurs it is often mistaken for insulin reaction even though they are entirely different. Insulin reaction is caused by **too much insulin**; a coma is the result of **too little insulin.**

Unlike insulin reaction, acidosis and coma develop gradually, often taking several days. **The symptoms start with an increased thirst and urination. Hunger, weakness, loss of appetite, nausea, vomitting, rapid deep breathing and dimness of vision and finally unconsciousness.** Both serious insulin reaction and diabetic coma require prompt treatment by a doctor.

Identifying The Diabetic

Insulin reaction or a diabetic coma can be easily mistaken for intoxication. Fortunately, advances in medicine have reduced the frequency of these acute conditions. Nevertheless, these extremes do occur and have at times been misjudged by police officers.

One of the first examinations to be conducted at the scene is to smell the subject's breath. If the odor of alcohol cannot be detected, intoxication may be ruled out. A fruit like odor may indicate a victim of diabetic coma. This fruit like odor (*acidosis*) will likely be on the breath of an unconscious person.

IN EMERGENCY LOOK FOR MESSAGE ON THE BACK

MEDIC ALERT EMBLEMS are worn by Diabetics, Epileptics, Hemophiliacs, Laryngectomees (neck breathers), persons with Myasthenia Gravis, Multiple Sclerosis, severe allergies to horse serum, antibiotics, bee stings, persons taking anticoagulants, Cortisone and Antabuse.

There will be occasions when an intoxicated subject or a person with the odor of alcohol on his breath may also be suffering from severe diabetes. It takes a few minutes to question the subject or to check his identification to determine if he is a diabetic or suffering from another illness. If the person is conscious the officer may ask questions such as these:

1. *Are you a diabetic?*
2. *Do you take insulin?*
3. *Do you believe you are having an insulin reaction?*
4. *Are you under medication?*
5. *Are you being treated by a physician?*
6. *What is your doctor's name? What is he treating you for?*
7. *Are you injured or sick?*
8. *Do you have any physical defects?*

Diabetics under the care of a physician will normally possess a diabetic identification card. Others may wear an identification bracelet, watch band or locket. If insulin is used in the treatment, the identification will also contain the type and dosage of insulin the person receives.

I AM A DIABETIC
(I Am Not Intoxicated)

If I am unconscious or behaving peculiarly, it is probably the result of insulin overdosage. Please follow the emergency instructions on the reverse side of this card.

(over)

I am a diabetic. Please place some sugar or candy in my mouth and call my doctor or emergency hospital.

Name _____

Address _____ Phone _____

Doctor's Name _____

Address _____ Phone _____

Printed In U.S.A. J71-69 (over)

The absence of information does not necessarily mean that the person is not ill or a diabetic. Never assume that such a person is just another "drunk." If you have any doubt at all, or if the person is unconscious, have him examined by a physician.

Emergency Treatment

When you have determined a person is experiencing an insulin reaction and is able to swallow, *OFFER HIM SWEETS OR STARCHY FOOD—CRACKERS, SLICE OF BREAD, CANDY, ETC.* Recovery from this condition is surprisingly rapid. It is then advisable to remove the person to a hospital or medical facility. Victims suffering from diabetic coma should be transported to the hospital for immediate care.

QUESTIONS . . .

1. **Diabetes is a disease resulting from a defficiency of a hormone called:**
   a. estrogen
   b. adrenalin
   c. insulin
   d. thyroxin

2. **A police officers first action when confronted by a suspected diabetic arrestee is:**
   a. make him comfortable and observe closely
   b. introduce food into his mouth
   c. procure medical aid
   d. all of the above
   e. none of the above

3. **Diabetes has several warning symptoms. Which of the following is *not* associated with this illness:**
   a. excessive appetite
   b. excessive thirst
   c. excessive energy
   d. excessive loss of weight

4. **Insulin reaction occurs when too much insulin is introduced into the system. Which of the following is symptomatic of this condition:**
   a. belligerency
   b. convulsions
   c. loss of bladder control
   d. all of the above
   e. none of the above

HAVE YOU READ . . .

FACTS ABOUT DIABETES. American Diabetes Association, Inc., New York 17, New York. 1956. 35 pp.

This pamphlet describes the symptoms of this disease along with the kind of care the diabetic should take. Two special sections also discuss the progress made in the search for oral medication.

YOU AND DIABETES. The Upjohn Company, Kalamazoo, Michigan, 1959. 20 pp.

This booklet was prepared to inform its readers about diabetes and how to live with it. It stresses that there is no substitute for the instructions a doctor can give.

THE THREE R'S OF DIABETES CARE. U.S. Vitamin & Pharmaceutical Corporation, Arlington-Frank Laboratories Division, 250 East 43rd Street, New York 17, New York. 19 pp.

This public information pamphlet explains the basic rules to follow when afflicted with diabetes. It describes the proper method of giving insulin injections.

YOUR DIABETES AND HOW TO LIVE WITH IT. F. L. Rogers, University of Nebraska Press, Lincoln, Nebraska, 1953.

An excellent, interesting and authoritative work relating to diabetic management. Written for the layman, it discusses and explains the importance of proper care, diet, exercise and medication.

ANSWERS . . .

1. c. Diabetes results from an insulin deficiency. Insulin is a hormone which governs the absorption of glucose by the body cells.

2. c. Life or death may depend upon a quick diagnosis and only a doctor has this legal capability.

3. c. Due to the fact that body cells cannot use the fuel energy of the blood sugar, a diabetic is usually easily fatigued or drowsy.

4. d. All the answers are conditions symptomatic of insulin reaction.

APPENDIX J

IACP TRAINING KEY:

"SEVERE MENTAL ILLNESSES"

SEVERE MENTAL ILLNESSES

All murders are horrifying, but the crime committed by a demented person—the mass slaying of a number of innocent victims chosen at random—produces an almost hysterical quality of shock and dread to a stunned populace. The magnitude of this slaughter achieves national prominence and reinforces the many fears and misconceptions of mentally ill patients. Yet these cases are isolated instances of extremes in abnormal behavior. Most persons suffering from severe mental illnesses *(psychoses)* are harmless and helpless. Actually, they are a greater threat to their own welfare than to the safety of those around them.

Psychosis

A phychosis is a severe mental disorder in which the patient loses contact with reality. He sees life and his surroundings in a way that is unique to him. He operates in his own world. Time and space have no meaning. His behavior is peculiar, his speech is irrational and he appears to lose all concern for the world in which he physically lives. However strange his world may appear to others, it is reality to him. This serious disorder requires extensive medical treatment and has a disintegrating effect on the personality.

Psychoses are classified as *organic* and *functional*. The *organic psychosis* results from physiological changes occurring within the brain. It may be caused by:

1. *infection*
2. *cell deterioration and poisoning from excessive use of drugs and alcohol*
3. *severe or repeated blows to the head, causing tissue damage*
4. *blood vessel degeneration*

A *functional Psychosis* is the result of overwhelming personal problems and conflicts, or a life of poor adjustment habits. The organ (brain) is healthy but it functions improperly.

Organic Psychoses

SYPHILITIC PSYCHOSIS *(Paresis)*: Some years ago this disorder constituted about ten per cent of all commitments to mental hospitals. In recent years, the sharp increase of infectious syphilis, especially in the 15 to 19 year-old age group, may add further significance to syphilitic psychosis. This mental illness is caused by the syphilitic infection of the spinal cord and brain.

Symptoms: A loss of memory and of judgment are among the first signs of this disorder. It is soon followed by irritability, restlessness and poor emotional control. The patient has marked tendencies towards alcohol and sexual excesses which are sometimes mistaken for faults of character. As the disease progresses, the physical changes in the brain affect the speech. It is marked by excessive slurring. There is a noticeable hesitation in the speech and the omission of words and phrases. Djsorders in movement also occur. The patient drags his feet and walks with a shuffling gait. He may have delusions of grandeur and show symptoms of depression and melancholy.

ALCOHOL PSYCHOSIS: Mental dullness, irresponsibility, a physically run down condition and appearance, identifies the chronic alcoholic. He is a difficult subject to question because he shows a lack of attention and is unable to separate reality from fantasy. He may suffer from *Delirium Tremens* (D.T.'s). While under such an attack, he may be subjected to frightening hallucinations. He is more likely to "see" monstrosities of the animal or insect world rather than the proverbial pink poodle or elephant. He may "feel" them crawling over his body or "attacking" him. Although his behavior may appear to be highly unorthodox and amusing, this is no laughing matter. The patient may violently react to these hallucinations, and in his fright may require restraints during transportation. **He must receive immediate medical attention** as a high per cent of these attacks are fatal. **Never place this patient in a cell without first obtaining medical examination and treatment.**

DRUG PSYCHOSIS: The drug psychotic is called an addict. He is suspicious, a liar and harbors delusions of persecution. His memory is poor and he lacks social and ethical values when he is deprived of drugs and narcotics.

TRAUMATIC PSYCHOSIS: This mental illness is caused by wounds or lesions of the brain. It may be the result of a severe blow to the head which damages brain tissues or from a series of repeated concussions which cause the blood vessels to contract, thus reducing the normal supply of oxygen to the brain. These frequent impacts may eventually damage the brain and cause personality changes.

Symptoms: Typical of this behavior is the eccentric conduct, halting speech, delusions and hallucinations of the "punch drunk" fighter.

SENILE PSYCHOSIS—*Psychosis of Old Age:* When chronic mental disorders occur in elderly per-

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sons and is accompanied by mental deterioration, it is known as senile psychosis. This illness is the result of a reduction in the supply of blood and oxygen to the brain by the hardening and thickening of the blood vessels in the brain.

Symptoms: The senile person has difficulty getting along with people. He becomes childlike in his habits, quarrelsome and hoards strange objects. He is unclean, selfish, and often comes into conflict with his neighbors, who complain of his habits. Children often annoy him and he shows an aggressive behavior toward them. He has a tendency to wander and becomes forgetful. He may leave his house, walk a short distance and forget where he was going or where he is. He may not remember what he ate for breakfast but will vividly describe events in his youth. As the illness progresses, his speech becomes rambling and incoherent and he may tell convincing lies to compensate for his inability to remember recent events. In some instances, he may even fail to recognize relatives.

Functional Psychoses

These mental disorders are basically the result of poor personal adjustment to life situations. The brain is apparently healthy but functions improperly. Schizophrenia, Paranoia and Manic-depression are the three general classes of functional psychoses.

SCHIZOPHRENIA: Disturbed relationships with people and their surroundings are the common symptoms of a schizophrenic patient. This illness may develop over a period of years, while in other cases the change may be very rapid.

Symptoms: The less severe form of this illness is known as *simple schizophrenia*. The symptoms range from a gradual loss of interest in people to an increasing ineffectiveness in meeting social demands. The patient withdraws into a solitary life. He usually shows a marked apathy and irresponsibility and tends to be preoccupied with his own inner thoughts, ideas and fantasies. In some cases he may demonstrate a lack of emotional responsiveness to other people and the patient takes a line of least resistance. These persons become without any reluctance, alcoholics, idlers, petty thieves or prostitutes. The most violent reaction is an occasional irritability and grouchy refusal to accept pressure or suggestions from others.

PARANOID SCHIZOPHRENIA: Those affected by this disorder may produce a behavior of serious consequences to the community. Its outstanding features are strong, numerous and fantastic delusions accompanied by hallucinations.

Symptoms: This disturbed person not only believes people are plotting against him, persecuting him or depriving him of his rights, but he can *"hear"* them or *"taste"* the poison in his food. He *"sees"* them lurking at his window, under furniture, and can *"feel"* the electricity or radar waves which are being directed at him by his enemies.

This type of mentally ill person becomes highly suspicious and defensive. He may become a chronic complainer about the morals and character of his neighbors, or he may accuse members of his family of trying to kill him. He may also be convinced that his enemies have listening devices hidden in his home. As long as he maintains a defensive behavior, he poses little physical threat. However, he may also become aggressive and violent. He may then register complaints about the police, initiate lawsuits, and frequently resorts to violence against those whom he feels are his enemies.

In the more serious cases, he is deluded into believing he is immortal or a biblical being and may assume the identity of an historical or an important person. He can hear voices announcing his fame or bringing important messages to him directing him to eliminate enemies or to reorganize society. At first it is generally possible to see a connection between the patient's delusions and his personal wishes, needs and fears.

Although most psychotics are harmless and helpless, the paranoid-schizophrenic is a powder keg of lethal emotion. He lives in an unreal world and is haunted by fears and delusions of persecution and grandeur. In his sick mind, an accidental bump on a crowded sidewalk, a passing criticism from a member of his family or employer can be transformed into an illusion that the world is plotting against him. A harsh word or threatening gestures by a uninformed police officer (or other authoritative person) may trigger a violent reaction.

CATATONIC SCHIZOPHRENIA: This form of schizophrenia is one of the most intense demonstrations of withdrawing from reality. It is represented by two distinct phases: 1) *Catatonic Stupor*, which may last for extended periods, going on sometimes for weeks and months, and 2) *Catatonic Excitement*, which is usually of short duration.

Symptoms: Peculiar postures, gestures or grimaces endlessly repeated are typical of *catatonic stupor*. A patient can be identified by his slow and infrequent motions and may remain immobile or "statue like" for hours on end. He may also lie still as if unconscious.

Catatonic excitement is dramatically opposed to stuporous behavior. The patient literally goes berserk. In this extreme violence, he may smash furniture, assault those around him and pose a real danger of both homicide and suicide. Sometimes this frenzy is accompanied by delusions and hallucinations of great power. At other times it is more like a wild, disorganized outbreak of energy. These are the persons who for no apparent reason become "raving maniacs" at home or in a public place. Although these physical outbursts are usually of short duration, they cause considerable problems while they last.

PARANOIA: The true form of this illness is seldom encountered. It is distinguished from paranoid-schizophrenia in that the patient does not have hallucinations. The falsification of reality is restricted to his delusions, which are strongly entrenched. This patient offers a considerable challenge because he has no loss of intellectual effi-

ciency. He appears well oriented and normal in his conduct. Furthermore, he is so persuasive and logical that his ideas are accepted by others who are not mentally ill.

Symptoms: The paranoid appears quite normal in his conversation, emotions and general behavior. It is only in the area of his delusions, which usually center on a persecution complex, that he betrays his disturbance. Since he has convinced himself of his delusions, he cannot tolerate criticism of his ideas. Questioning results in evasiveness, defensiveness, irritability and hostility.

The paranoid is potentially dangerous. He is the assassin of rulers and other important personages. He is also the murderer of innocent victims who, in his warped mind, should be killed for the good of society. He fancies himself as an avenger, or a person dedicated to cleanse the world of misfits, of persons he believes are evil or enemies.

Another characteristic of paranoia is a suspicious reaction to others. The patient spends considerable time reading derogatory motives into the actions and statements of people he meets.

MANIC - DEPRESSIVE PSYCHOSIS: *Mania* (overactivity) and *melancholia* (depression) were the earliest mental disturbances recognized by man. At one time, this illness was called *"cyclical insanity"* because of the emotional extremes that sometimes appeared in a patient. Although some patient's emotions run the gamit from high elation to deep depression, most patients are either manic (overactive) or depressives.

Symptoms: In its lesser form, mania may range from a feeling of well-being, overenthusiasm and talkativeness to extreme confidence and boastful self-assertion. This behavior may perplex the family and friends of a patient, especially if he is known to be a quiet or a reserved individual.

In the more acute cases, the speech of the disturbed person may become disjointed and endless. He may talk about a variety of topics and be continuously shifting from topic to topic. His prevailing mood is that of elation and overconfidence. He is always busy, but never accomplishing a thing. He is seldom tired and requires little sleep.

A manic operates at full throttle. If he cannot find enough to do, he may use up his energy shouting, singing or smashing furniture. He is inconsiderate of others and is easily aroused to anger and fury if his activities are curtailed. He may display a domineering arrogance, especially towards authority. His delusions center on grandeur—great wealth, accomplishment, fame, etc., but his distortion of reality does not extend to hallucinations. The effect is that of a person highly speeded up, totally disorganized but not unintelligible.

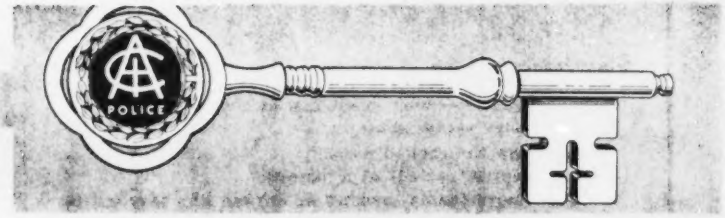
The symptoms of depression can be generalized as underactivity and melancholia. In the mildest form, they show themselves as discouragement, feelings of inadequacy and underactivity of movement and speech. When such a person is questioned, he speaks slowly, in a low tone and with great economy of words. The more serious cases of depression assume forms of overwhelming sadness and morbidness. The patient cannot be cheered—his whole outlook is that of gloom. He paints a picture of utter hopelessness. He may believe he is suffering from an incurable disease or that his internal organs are rotting away. More characteristic are delusions of unworthiness, sinfulness and worthlessness and of self-blame for the wrongs in the world. His hallucinations also border on the macabre or morbid. He sees skeletons, open graves and hears the voices of the dead, etc.

A patient in deep depression is a potential suicide. He groans, moans and squirms, tries to hide because of his shame or unworthiness. Self-condemnation may also lead him to confess to crimes he did not commit.

DANGER SIGNALS

Severe mental illness can usually be detected by a sudden behavioral change or a gradual deterioration of the personality and an alteration in the behavioral pattern of a person. The appearance of even all the symptoms denoting mental illness does not necessarily mean that a patient will commit suicide, turn killer or inflict physical harm. They do, however, mean that **such a person is in need of medical attention.** We simply cannot arrest people because they are ill. Their actions must first of all conflict with our laws. We can, however, recognize these danger signals so that we can advise those concerned that medical attention is required.

1. **A change of attitude towards friends and relatives**—a habitually shy and quiet person suddenly becomes aggressive, talkative, selfish and the like, or vice versa.
2. **Unusual or bizarre mannerism**—any radical change in normal eating or sleeping habits. A sudden carelessness about personal appearances and hygiene, etc.
3. **An increase or decrease in efficiency**—absentmindedness, excessive drive or activity or a noticeable decrease in work efficiency.
4. **Argumentative and uncooperative** — uncontrolled outburst of temper at the slightest provocation, unfounded jealousies and withdrawal from others.
5. **Development of hostility to suggestions and growing distrust of people**—a growing hypersensitivity to slight criticism or insults or unfounded suspicions of relatives, friends, strangers, etc.
6. **Disorganized thinking and morbid interest in such potential tools of destruction as guns and knives.**
7. **Subjected to hallucinations and delusions**—hears noises or voices, believes he has mystical power, an incurable disease, etc. He believes that certain religious groups, secret societies or agents of foreign powers are responsible for all his difficulties. He may also display an unnatural fear for his life.



Discussion Guide

PURPOSE

1. . . . To define and explain some terms used in the Training Key.
2. . . . To review methods of handling the mentally ill patient.
3. . . . To stress the importance of obtaining medical assistance when dealing with the acute alcoholic.
4. . . . To discuss various field problems involving the mentally disturbed.

DISCUSSION QUESTIONS

1. The terms delusions, hallucinations and illusions are found in this Training Key. Because they are infrequently used, their meaning is often confused.
   - **A. What are delusions?**
     - **. . . false beliefs or ideas**
     - **. . . when they persist or control behavior, they are a symptom of mental illness**
     - **. . . a person who believes he is the Angel Gabriel**
     - **. . . a person who believes he has hidden enemies**
   - **B. What are hallucinations?**
     - **. . . perception that is not based on reality**
     - **. . . hearing imaginary voices—ghosts, angels enemies**
     - **. . . seeing, feeling tasting and smelling things that do not exist**
   - **C. What are illusions?**
     - **. . . misinterpretation of something seen, heard, tasted, touched or smelled**
     - **. . . a mirage—misinterpreting heat waves for water**
     - **. . . an automobile backfire misinterpreted as a gun shot**
2. An assignment dealing with a severely mentally ill person may represent anything from a peaceful removal to a situation posing a threat to the safety to a number of persons, including the police. Discuss the general guidelines to be followed in these situations.
   - **A. Receiving the assignment**
     - **. . . obtain as much information as possible from the dispatcher**
     - **. . . get some idea of the situation**
   - **B. Arriving at the scene**
     - **. . . do not park vehicle directly in front of the house**
     - **. . . ask questions from the people at the scene**
     - **. . . call for assistance**
     - **. . . wait for help**
     - **. . . make a plan of action**
     - **. . . keep calm**
   - **C. Confronting the mentally ill person**
     - **. . . manpower is important**
     - **. . . most patients want help**
     - **. . . reassure patient you are going to help him**
     - **. . . be firm—don't humor; patient wants to be reassured**
     - **. . . don't argue with his delusions**

NOTES

DISCUSSION QUESTIONS (Cont'd.)

... be gentle—don't insult him or show disrespect
... ignore verbal abuse

D. Calming the excited patient
... keep the curious at a distance
... remove family member or anyone who may excite patient
... insist you are going to help and protect him
... physical pain will not calm mentally ill person

E. Violent patient
... excitement is usually of short duration
... often a show of force with reassurances that the patient will be cared for is enough
... if patient struggles, arms and legs are restrained. Do not strike blows or inflict pain
... after the patient is initially subdued, use rug, blanket or sheet to immobilize
... small mattress, sofa pillows, or chair can be used for protection and subduing violent patient
... use handcuffs or other restraints for transportation
... keep reassuring him you are going to help him

3. The alcoholic found lying in the gutter or in a doorway needs to be regarded as a seriously ill person. He must not be dismissed as just another drunk.

A. Acute intoxication may hide other illnesses
... diabetes
... mental illness
... heart trouble
... injury, etc.

B. *Delirium Tremens* is caused by acute alcoholism.
... although actions may be humorous, don't dismiss this condition
... D.T.'s may cause death
... have patient medically examined
... never place in cell without medical treatment

4. Mentally disturbed persons become a concern to the police because their behavior differs from what is regarded as normal. They may also actually pose a threat to the safety of others or to their own welfare. Basing your discussion on departmental procedures, policies and the legality of your actions, explain how you would handle the following situations.

A. You observe an elderly gentleman walking in the middle of the roadway, causing a traffic tie up. He is carrying a shopping bag, his clothing is in disarray and he is in need of a shave. You try to question him but he cannot recall his last name nor his address. The shopping bag contains rags, old newspapers and a loaf of bread.

B. You receive a call to investigate a disturbance. Upon arrival, you find a woman waiting in front of her home, who states her husband has been drinking and has assaulted her. He is now threatening to "get even" with his neighbors, whom he believes want to kill him. The man is still in the house, armed with a knife.

C. An excited citizen calls the police to report there is something strange going on next door and is willing to sign a complaint. You proceed to the address in question and you are greeted by a middle-aged woman, who tells you that she knew that sooner or later the police would be coming to check on her son. You are taken into a room and there you see a young man in his late teens sitting naked on the floor cutting paper dolls and babbling like a small child. The mother informs you that he is not dressed because he tears off his clothing. What action do you take?

NOTES

QUESTIONS . . .

The following questions are based on material in this Training Key. Select the best answer.

1. **A severe mental illness in which a patient loses contact with reality is known as**
   - *a. psychosis*
   - *b. neurosis*
   - *c. psychopathic disorder*
   - *d. personality disorder*

2. **A patient suffering from *Delirium Tremens* should be considered as**
   - *a. a drunk who needs to "sleep it off"*
   - *b. an alcoholic having hallucinations, who must be jailed for his own safety*
   - *c. an alcoholic having hallucinations, who requires immediate medical attention*
   - *d. a drunk who is putting on a show to evade arrest*

3. **Schizophrenia is a severe mental illness. Which of the following symptoms are NOT related to this disorder?**
   - *a. the patient suffers delusions of grandeur*
   - *b. the patient has delusions of persecution, accompanied by hallucinations*
   - *c. the patient is in a stuporous condition, remaining immobile for an extended period of time*
   - *d. the patient has delusions of worthlessness and his hallucinations center on the morbid*

4. **There are numerous danger signals calling attention to mental illness. Which of the following are considered to be such symptoms?**
   - *a. disorganized thinking and morbid interests*
   - *b. change of attitude towards friends and relatives*
   - *c. unusual or bizarre mannerisms*
   - *d. all of the above*
   - *e. none of the above*

HAVE YOU READ . . .

PSYCHOLOGY FOR LAW ENFORCEMENT OFFICERS. (2nd printing), George J. Dudycha, Charles Thomas, Publishers, Springfield, Illinois, 1960. 420 pp.

A basic textbook which discusses the various areas of the police task in which a knowledge of psychology may be helpful. Chapter 9, "Mental Abnormality and Crime," Don W. Dysinger, defines mental abnormality and explains its causes and types of mental disorders.

THE DISORGANIZED PERSONALITY. George W. Kisher, Ph.D., McGraw-Hill Co., New York, San Francisco, Toronto, 1964. 631 pp.

The Disorganized Personality *is a book dealing with the troubled mind. The volume was written in response to a need for an introductory textbook which would reflect the progress that has occurred in the field of mental health. It introduces the reader to the field of abnormal psychology, discusses the contributing factors to the various personality disturbances and deals with the various treatment methods.*

THE PSYCHOLOGY OF ADJUSTMENT. (2nd edition), Lawrence F. Shaffer and Edward J. Shoben, Jr., Haughton Mifflin Co., Boston, Massachusetts, 1956, 672 pp.

This text was prepared as an introduction to psychology. It gives the reader information about the mental life of normal and abnormal human beings. Its appraisal of psychoanalysis affords a meaningful insight into the understanding of human nature.

TRAINING KEY #32, *"MENTAL ILLNESS."*

This issue of the Training Key introduces the reader to the various kinds of mental illnesses; it defines and illustrates such terms as illusion, delusion, and hallucination. It also lays the ground work for the identification of the mentally ill and establishes guidelines for dealing with such cases.

ANSWERS . . .

1. a. A psychosis is a severe mental disorder in which the patient loses touch with reality. Both answers (e) and (d) are serious disorders but the patient does not lose contact with reality.

2. c. Since a high per cent of persons suffering from *Delirium Tremens* die, such a patient must be given immediate medical attention.

3. d. These are symptoms of the depressive and not the schizophrenic.

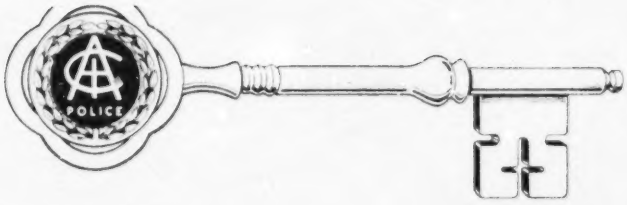
4. d. All of the above. All are symptoms of mental illness.

APPENDIX K

IACP TRAINING KEY:

"IMPRC VING THE OFFICER/CITIZEN CONTACT"

TRAINING KEY #94



IMPROVING THE OFFICER/CITIZEN CONTACT

Officer citizen contacts produce some of the more difficult situations facing the police officer. The reasons for this are rather obvious. In the first place, police officers frequently have to take action in conflict situations—perhaps a fight or at least an altercation. Secondly, some contacts result in an arrest and very few people want to be deprived of their freedom. This places the officer in the position of sometimes forcing people to do things to which they strongly object. Even a relatively minor police contact, such as is required in an ordinary traffic violation, produces a degree of resentment. Third, the policeman is often unavoidably in the position of acting as a community disciplinarian and no one likes to be disciplined. Finally, an officer sometimes has to detain a person momentarily for questioning as, for example, when making a field inquiry. Many persons questioned in this manner resent the procedure and react with hostility and occasionally violence. Thus, within most of his daily activities the officer is confronted by situations having built in conflict possibilities. These, of course, make the job more difficult and unpleasant.

Be Aware of Your Behavior

Because of the nature of your official responsibilities and the often highly charged emotional climate in which you work, it is essential for you to be skilled in the art of dealing with people. If you develop effective methods of dealing with people under difficult circumstances, you can make your job easier, more pleasant and less dangerous.

The circumstances of an encounter may not always be entirely under your control, yet certain things that you, as an officer can do will help. For your own self-interest, you should make a study of these matters and carefully analyze your behavior in order to eliminate ineffective or trouble-breeding contact techniques and, if necessary, adopt new and better methods—*(consider courtesy, tone of voice, vocabulary—general attitude towards citizens etc.)*

A contact with a citizen is important also from another point of view, you are not the only one affected. Each meeting, confrontation, and the like, produces some kind of result beyond the immediate situation; **every contact has some impact upon the police image.** The citizen you encounter for whatever the reason carries away with him **an impression** of you—not as a person necessarily, but **as a policeman.**

He pieces together the impression you made upon him with the notions he already holds about the police. Your contact may serve to reinforce his negative attitudes concerning police officers or, on the other hand it may cause him to reappraise his views. Your behavior then influences the other person's attitudes and beliefs about policemen and can either be helpful or harmful. If what you do and the way you do it makes a good impression, **not only is that specific incident made easier for you, but you have also helped to make it better for a fellow officer who may have to deal with that person in the future.**

So far we have been considering incidents in which there is a direct personal contact between you and someone else. Such direct confrontations are the most important because they leave the strongest impression. However, we must all realize that we leave impressions with people we do not directly contact. The way we wear the uniform and the things we do as public figures make a difference. **Your general demeanor in public is important all the time, to you, to your fellow officers, to your department and to policing as a profession.**

What are the kinds of contacts you make in your official "on-duty" capacity and what do you hope to accomplish? How does your identity as a policeman affect your non-official contacts? Does the generalized police image held by the individual you are confronting affect the nature of the incident? These are among the many important questions, the answers to which have a significant bearing on how you make an approach and the way you handle an incident.

As a basis for improving our contact abilities, we must understand clearly that there is no such thing as *the* police role. There are many different angles to police work, each of which calls for a somewhat different role. It is plain to see that the public views in different ways an officer directing traffic at a busy intersection and a detective working in plainclothes investigating a murder. So do policemen, for that matter. It is also clear that the role of the chief is not the same as that of the patrol car officer. The point here is that these different roles call for different kinds of approaches to contacts and involve different aims in making contacts.

Differences in Situations

We must also understand that the way you—as a patrolman, detective, sergeant, or whatever you may be—fulfill your role must also differ from time

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to time depending upon the circumstances. For instance, the nature of your contact with a merchant who is reporting a burglary would be, in some important respects, different from your contact with a suspicious character on the street late at night. You would play your role according to what each situation requires. There would be some similarities and some differences in these two contacts.

The table reflects just some of the factors involved. The list could be extended to take in many other aspects. However, these will suffice to show the necessity for a different kind of approach to the police role. It is clearly necessary to be on guard when contacting the suspect, but one would not anticipate any physical danger when contacting the merchant. While both individuals *may* be cooperative, failure to cooperate would be more likely on the part of the suspect. While both *may* show hostility, the suspect would be more likely to do so.

Contact Elements	*Merchant reporting a burglary*	Field inquiry of a suspect
Contact initiated	*By merchant*	By officer
Reaction by other party	*Interested, wants to talk to you. Thinks he may gain.*	Resentful and/or frightened; does not want to talk to you. Thinks he may lose.
Exercise of authority by you	*Usually not applicable.*	Authority imposed upon suspect.
Asking questions	*You take initiative.*	You take initiative.
Search of person	*None.*	May search.
Your attitude	*Sympathetic.*	Suspicious.
Possible outcomes	*Assure merchant case will be investigated; may advise re security.*	May assure persons nothing to worry about; or give warning; give advice; make arrest.
Your aim	*To get as much accurate information as possible.*	To get as much accurate information as possible.

What these differences, similarities, and possibilities point out is the need for flexibility and a wide range of skills in handling the many types of contacts you must make. Flexibility is required when you change shifts, when you work with a new partner, when you are assigned to a new area. Flexibility is required when you are promoted to a supervisory position. Flexibility is required to adapt to new policies and to meet new or unusual conditions in the community.

Flexibility means you can "roll with the punches." You are not rigid in the way you handle things. You can "size up" a situation and plan your approach, employing the proper combination of skills to best advantage.

Some contacts call for skills that are predominantly verbal. Words are tools and the ability to use them effectively is even more of an asset than skill in the use of a fingerprint dusting kit, tear gas, or your gun, important as these are. Some contacts call for a combination of verbal and physical skills as, for example, when restraining a violent person. Some call for a combination of physical and technical skills as well as verbal ability as, for example, when fingerprinting a hostile person. When we get right down to bedrock, we find that the fundamental skills required to be a good officer are psychologically identical with those needed to be a success in many other occupations or, for that matter, life in general.

The officer who wants to improve his contact ability must develop his skill in observing accurately and his ability to interpret realistically his observations. He must be sensitive to changing conditions in the world and particularly in his community so that he will better understand the effects of the changes on his role as a public official. In addition, and very important to success, he must understand himself. He must try to be as realistic and objective in appraising his own strengths and weaknesses as he is in making such judgments about others. Flexibility and objectivity are difficult to achieve, but they are wonderful assets which all should strive toward.

The Officer: A Controller of People

Many people look upon an officer as a "take charge" person. They expect an officer to assume control in many situations, especially in emergencies and in public places because it is he to whom they look for guidance in a confusing situation. This element of control is an important aspect of the police function. People, in general, including many who are usually hostile to the police, readily accept direction and control when they regard them to be legitimate and fair. In most cases little trouble results when the police require people to stand back at the scene of an accident or a fire. Driving on the right-hand side of the street, stopping for red lights and similar restrictions are accepted by most people as reasonable controls. One kind of control measure that often meets resistance is the situation in which an officer deems it necessary to order people to move on or "break it up" and is not regarded as a fair or legitimate order by the citizens.

The extent of the legal control we can impose is limited by the Constitution and the laws. It often becomes a problem in balancing the requirements of public safety and order with individual freedoms and rights. This is one of the reasons we need good officers. If the job were simply a matter of following instructions, anyone could be a policeman. Despite these uncertainties and difficulties, controls aimed at public safety, order, justice and crime prevention remain our primary objectives.

Sometimes control can be achieved easily by the right word at the right time. Other times it takes physical force. We need to study these matters in order to improve our effectiveness, employing the first way as much as possible and turning to the second only as a last resort.

Discretion: The Better Part of Valor

Every officer must use discretion in deciding what to do in a given situation. The "book" doesn't always give you the answer; you usually have choices. If in a crowd two men get into a fight and trade punches, you could decide to arrest them, charging each with assault. In some crowd situations, that would be just the "trigger" needed to set off a major disorder. Is it not possible that discretion and good judgment in some cases would dictate that a better course would be to separate the combatants and try to "cool" things without making arrests? Sometimes when a man takes a swing at you, the best course is to retaliate promptly with sufficient force to stop it right now. At other times, it is far better to take evasive action. If the man is so drunk that his punch misses you by three feet, you would look pretty silly beating him up in front of people who know that you do not need to do this in order to gain control. This is what is meant by the wise use of discretion.

Some Concrete Suggestions

What we are all looking for are ways of getting the job done effectively but with as little difficulty as possible. We want people to think well of us, to respect us and to cooperate with us. From a personal point of view, we want to do an effective job so we can get ahead—so we can earn those promotions. We want to handle each contact in such a manner that it will pave the way for an easier and more effective contact the next time. Here are some suggestions that will help:

1. *Use a polite, unexcited or calm reasoning approach whenever possible. Try to be impersonal from two points of view: (1) Remember the authority you wield is that of the people and not yours personally, and (2) Try to remain detached and not take as a personal insult or affront the reaction of people to your authority.*

2. *Be businesslike and self-assured, not showing anger, impatience, contempt, dislike, sarcasm, and similar attitudes. Try to avoid a perpetual scowl and a forbidding, hard-boiled exterior.*

3. *Size things up as accurately as possible before making the contact. Get complete facts as quickly as possible* before *committing yourself to an irreversible course of action. Be open-minded in evaluating the facts.*

4. *Once you have the straight story, make your decision based upon the policies and procedures under which you work and take decisive action.*

5. *Offer explanations where advisable, but do not be trapped into arguing.*

6. *Be civil and courteous. Use* **"Mr."** *and* **"Mrs."** *in addressing people. Never be officious. Avoid profanity and insulting and belittling terms. Use* **"thank you," "I'm sorry," "please,"** *and other amenities of ordinary speech where appropriate. Use physical force only when unavoidable.*

7. *Show by your demeanor that you are not looking for and you do not expect any trouble (here is where your acting ability comes in handy . . . remain alert and be prepared to shift your course of action instantly, but do not let your suspicion show). Try to get the contact started off on the right foot. Let the other person know that you are not going to be difficult to deal with and that you also expect him to be reasonable. You are competent and trained . . . Show by your approach that you are confident and in control of the situation.*

8. *Try to avoid giving people the impression that your presence constitutes a threat—either physical or psychological. Bear in mind that a person will react as strongly to belittling or discourtesy as he will to a physical threat. If he does not regard you as a threatening person, he will not be so apt to be hostile. In this connection, frequent contacts with people under non-conflict circumstances will help. . . . Make more of them.*

9. *Some officers display only a hard and tough attitude. They tend to hold themselves aloof and to be unapproachable. This makes a bad impression and is looked upon as a challenge by a lot of people. Juveniles and adults have been known to describe such officers as swaggering, arrogant, insolent and conceited show-offs. If you leave this kind of impression, you are in for trouble.*

10. *The role of the police is not exclusively an authoritarian one. Police are not the "parents of the community" in a disciplinary sense. Our control powers are limited by the law and we are not, beyond that, guardians of the people's morals and regulators of their conduct. Let us not try to solve all of the community's problems. If we put more emphasis on protection of public safety and prevention of crime, we can gradually enlist the cooperative good will of more and more people for the accomplishment of the mission they have given us.*

QUESTIONS . . .

The following questions are based upon material in this Training Key. Select the best answer.

1. **Officer/Citizen contacts are said to produce some of the more difficult problems a policeman must face because:**
   a) Some contacts result in arrest and people generally do not wish to be deprived of their freedom.
   b) Some contacts momentarily detain a person for questioning against his wishes.
   c) The officer is often placed in a position of controlling or directing people.
   d) All of the above.

2. **The police/citizen contact is said to have some influence in creating an impression of the total police department.**
   a) False, because all citizens realize that the action of one officer does not speak for the department.
   b) True, because the citizen carries away an impression of the officer as an individual, not as a police officer.
   c) True, because to the citizen, your actions represent those of the department.
   d) False, because all citizens have strong feelings about the police and your actions will never change their attitude.

3. **Flexibility is necessary to deal successfully with situations and people because:**
   a) It allows the officer to deal with each situation as he sees it.
   b) It permits him to adapt more easily to changing situations and policies.
   c) It permits the utilization of the proper skills to handle a situation to the best advantage.
   d) All of the above.

4. **The police officer is generally accepted as a "take charge person." Which of the following situations would cause less resistance to controls?**
   a) When the controls are considered as legitimate and fair.
   b) When the controls are rigidly applied and deprive the citizen of his liberty.
   c) When force is used to deal with a situation that could have been handled with judgment, courtesy and patience.
   d) When the officer's task is regarded as legitimate but the method belittles, or embarrasses the citizen.

HAVE YOU READ . . .

POLICE AND THE CHANGING COMMUNITY. Selected Readings, Nelson A. Watson, ed., International Association of Chiefs of Police, 1319 18th Street, N.W., Washington, D.C. 20036, 1965. 240 pp.

This publication is a collection of articles appearing over several years in the POLICE CHIEF magazine. They were selected for their pertinence as reference material in the general area of police-community relations.

PROCEEDINGS OF POLICE ADMINISTRATORS CONFERENCE ON COMMUNITY RELATIONS. Jeptha S. Rogers, ed., International Association of Chiefs of Police, 1319 18th Street, N.W., Washington, D.C. 20036. 112 pp.

This work contains the proceedings, speeches, discussions of a conference of Police Administrators funded by the Office of Law Enforcement Assistance, Department of Justice. This meeting of police executives was conducted to arrive at police methods for working with community groups to prevent crime and disorder.

TRAINING KEY #42, "The Police Image."

This Training Key points out the importance of the police/citizen contact and the resulting influence this encounter has upon forming public opinion. It also discusses various opinion forming situations involving the police officer and the citizen.

TRAINING KEY # 51, "The Nature of Prejudice."

This Training Key discusses prejudice and the manner in which it affects interpersonal relationships. It calls attention to the police role and prejudice.

ANSWERS . . .

1. d) All the answers indicate some problem causing situations that result from police citizen contacts.

2. c) A citizen has a tendency to judge the police officer as an officer, not as an individual. Consequently, the police citizen contact may have an influence in creating an impression of the total police force.

3. d) Flexibility is needed to help the officer do a better job. All the answers indicate the need for flexibility.

4. a) Most citizens show little or no resentment to police control if it is applied legitimately and fairly.

APPENDIX L

Letter (to "All Police Departments and other Law Enforcement Agencies"), Office of the Maryland Attorney General, subject: "Comprehensive Intoxication and Alcoholism Control Act of 1968," dated August 26, 1968.

Offices of

The Attorney General

1200 One Charles Center
Baltimore, Md. 21201

August 26, 1968

TO: All Police Departments and other Law Enforcement Agencies

SUBJECT: Comprehensive Intoxication and Alcoholism Control Act of 1968

The purpose of this memorandum is to explore the Comprehensive Intoxication and Alcoholism Control Act (hereinafter referred to as the Act) and a companion statute, Chapter 666 of the Laws of Maryland of 1968, and the provisions thereof that concern the law enforcement agencies of this State, and to promote the uniform application of such provisions throughout the local sub-divisions of the State of Maryland.

The Act (Chapter 146 of the Laws of Maryland of 1968), effective July 1, 1968, eliminated simple drunkenness as a crime in Maryland by repealing the "found drunk" provisions contained in Article 27, title Crimes and Punishments, Section 122, subtitle Disturbance of the Public Peace, and also the "found drunk" and "habitual offender" provisions of Article 27, Section 123, subtitle Drunkenness and Disorderly Conduct, Annotated Code of Maryland (1967 Replacement Volume). Accordingly, since July 1, 1968, it is no longer a crime in Maryland merely to be found drunk in a public place.

The Act creates a misdemeanor described as "Disorderly Intoxication." It is unlawful to (a) be intoxicated and endanger the safety of another person or property, or (b) be intoxicated or drink any alcoholic beverages in a public place and cause a public disturbance. Conviction of "Disorderly Intoxication" is punishable under the Act by a fine of not more than $100.00 or by imprisonment for not more than ninety days or both.

Subsequent to the passage and signing of the Act, the Governor signed into law on May 7, 1968, Chapter 666 of the Laws of 1968 dealing with substantially the same subject matter but with some differences. Chapter 666 provides that, in the case of a person drinking in public and creating a disturbance, such person shall be first required by a law enforcement officer to discontinue drinking and creating a public disturbance, and upon compliance is not to be charged with any offense. Chapter 666 also provides for a penalty of not more than $50.00 or imprisonment for not more than sixty days, or both, and for a habitual offender penalty as described therein. The elements of the substantive offense described in Chapter

666 are practically identical to "Disorderly Intoxication" in the Act. Accordingly, we do not here reach any question of possible conflict between the two statutes.

The Act declares it the policy of the State of Maryland to consider chronic alcoholics to be sick people and not criminals. The Division of Alcoholism Control of the State Department of Mental Hygiene has the primary mission to administer the program described in the Act for the treatment and rehabilitation of alcoholics. Lacking adequate resources, the Division is not now able to fully perform its mission. In the interim, the Act assigns to the police an important role in the alcoholism program for an indefinite period but their functions are to be reduced to a minimum in the shortest practicable time. As its resources are increased and strengthened the Division of Alcoholism Control should assume greater responsibility for the program in accordance with the statutory mandate and the participation of the police should diminish accordingly.

Persons found drunk but not endangering the safety of another person or property, persons drinking alcoholic beverages in public but not making a public disturbance, and persons found drunk without involvement in any crime are not subject to arrest. This is not to say that persons found lying in the street or elsewhere in a drunken stupor are to be ignored. To the contrary, it is the intent of the Act that "the police shall make every reasonable effort to protect the health and safety of intoxicated persons." In so doing, the police are to be considered as acting in the conduct of their official duty. It is thus a statutory as well as a humane duty to help the helpless inebriate, a duty looming even more importantly with the approach of winter when the elements combine with his affliction to pose an added threat to the safety of the alcoholic.

A police officer coming upon a person incapacitated by intoxication, in such drunken condition as to be incapable of making a rational decision, should try to ascertain the identity and residence of the individual. An inebriate having a home should be sent home by commercial transportation, the police officer first taking reasonable measures to insure payment of the cost of transportation in advance.

An intoxicated person who is homeless or whose home address is not ascertainable should be taken or sent to the nearest detoxification unit or public health facility. Any intoxicated person who is incapacitated, or whose health appears to be in danger so as to require emergency medical treatment, should be taken to the nearest public health facility whether or not such person is charged with a crime. If the intoxicated person is not to be charged with any crime and has a home, and it appears that he (she), or family or friends, are able to make the necessary arrangements for care in a private health facility, the inebriate should be sent to a private health facility whenever practicable, otherwise such person should be removed to a public health facility.

If it has not been done already, all police departments and other law enforcement agencies should promptly inquire into the facilities that are available in their respective areas for the care and treatment of alcoholics. Where detoxification units or other public or private health facilities for the treatment of alcoholism as such do not exist, all facilities able to care for alcoholics in the acute stage of intoxication as the police are likely to find them, should be identified. All general hospitals should be canvassed for readiness to assume responsibility under the program and willingness to admit alcoholics. It is the legislative intent that inebriates and alcoholics be admitted to and treated in public and private hospitals without discrimination.

In areas where there are no public health facilities or detoxification units, or any general hospital or other facility that will accept alcoholics or inebriates, and the inebriate appears to be homeless or his (her) residence is unascertainable, such person should be taken to the police station, or to its counterpart outside of urban areas, in protective custody or safekeeping but not under arrest. Intoxicated persons brought to the police station should be held until they are sober and then discharged. As we have said, simple drunkenness is not a crime. Accordingly, if no criminal charge is filed against the inebriate there should be no entry on any arrest record or any other criminal record.

Very truly yours,

/s/ Francis B. Burch

Francis B. Burch
Attorney General

/s/ Fred Oken

Fred Oken
Assistant Attorney General